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July 18, 2005

Dr. Mark McClellan, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Ave., S.W.
Washington, DC 20201

Re: CMS-1290-P; Comments on Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for FY 2006; Proposed Rule.

Dear Dr. McClellan:

The Federation of American Hospitals ("FAH") is the national representative of privately owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching, short-stay and long-term care hospitals in urban and rural America, and provide a wide range of ambulatory, acute and post-acute services. We appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' ("CMS") proposed rule ("NPRM") regarding changes to the inpatient rehabilitation facility prospective payment system for FY 2006.

1. Background: General Comments

The FAH is concerned that CMS does not have adequate time to consider the extensive comments requested of the industry on this proposed rule. The FAH is also very concerned about the data used by CMS and RAND to develop the provisions of this proposed rule. There appear to be dramatic variances in the data based upon the facts and assumptions outlined in greater detail in our comments. As a result, the FAH strongly recommends that CMS implement a standard payment update only for FY 2006 and delay any implementation of IRF PPS refinement until the time that CMS has validated the accuracy of all data used by RAND and by CMS in refining IRF PPS and has considered the impact of the CMS 75%

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Chart 1: Medicare Rehab Cost per Admission

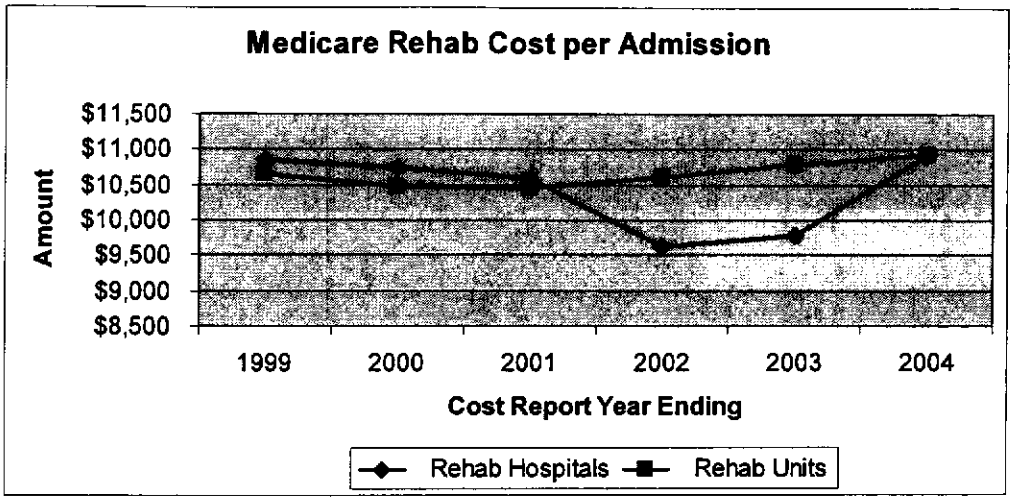

Table 2: Medicare Inpatient Rehabilitation Cost

Number of Cost Reports for Rehab Providers	1,186	1,166	1,256	1,187	1,197	601
Total Medicare Rehab Cost (1)						
Rehab Hospitals	1,340,696,103	1,424,437,327	1,783,387,766	1,524,859,168	1,652,924,369	662,727,566
Rehab Units	2,712,882,454	2,849,705,252	3,026,227,624	3,129,992,553	3,274,514,032	1,767,218,195
Total	4,053,578,557	4,274,142,579	4,809,615,390	4,654,851,721	4,927,438,401	2,429,945,761
Total Medicare Rehab Admissions (2)						
Rehab Hospitals	123,658	132,732	168,674	158,561	169,064	60,710
Rehab Units	255,002	272,314	289,787	295,245	303,580	161,964
Total	378,660	405,046	458,461	453,806	472,644	222,674
Medicare Rehab Cost Divided by Admissions						
Rehab Hospitals	$ 10,842	$ 10,732	$ 10,573	$ 9,617	$ 9,777	$ 10,916
Rehab Units	10,639	10,465	10,443	10,601	10,786	10,911

Total	$ 10,705	$ 10,552	$ 10,491	$ 10,257	$ 10,425	$ 10,913

Source: The data from this table came from cost report data, 3/31/2005 HCRIS update. The years are based on the cost report year end.

(1) The source of Total Medicare Cost was Worksheet D-1 part II Line 49 "Total Program Inpatient Cost".
(2) The source of Medicare Admissions was Worksheet S-3 Part I Column 13. Line 12 was utilized for hospitals and Line 14 and 14.01.

It has come to the attention of the FAH that HealthSouth eliminated 100% of the home office costs and a very large portion of depreciation costs from facility cost reports for FY 2002 and FY 2003. HealthSouth estimates that approximately $197 million in 2002 and $176 million in 2003 in allowable costs were excluded from these cost reports. (See specific comments on cost reporting issues submitted by HealthSouth Corporation for more detail.) As a result, the FAH believes that research data used by RAND and CMS in determining proposed refinements to the IRF PPS excludes these costs.

The cost issue related to HealthSouth hospitals explain part if not all of the cost issue that was found in the HCRIS data. The schedule in Table 2 shows how this error can have a significant impact on cost for various classes of hospitals. This understatement of cost for largely urban non-teaching hospitals likely would result in an inappropriately higher adjustment being needed for rural and teaching facilities. This cost issue could impact all the adjustments and/or weights within the PPS system if HealthSouth's facilities vary from the national averages.

The FAH strongly recommends that CMS delay implementation of any IRF PPS refinements until such time that the cost data for HealthSouth has been accurately reflected in any data used by CMS and RAND in determining proposed refinements to the IRF PPS. The FAH also recommends that CMS analyze and understand changes in the cost structure when the changes are this significant prior to making any change in the PPS amounts.

c. The FAH also noted an issue related to short period cost reports. Table 3 shows 54 rehabilitation hospitals had more than two cost reporting periods ending in 2001 compared to 6 or less for all other calendar years (1999 – 2003). This indicates there was an unusual number of short period cost reports in 2001 and possibly in 2002. Short period cost reports complicate financial analysis and modeling in many cases. Decisions must be made whether to utilize two short period cost reports or how to annualize the data if only one cost report is utilized. In addition, cost to charge ratios can vary significantly between these cost reports. The FAH is concerned that CMS and RAND did not fully adjust for these short period cost reports.

The FAH requests that CMS clarify how the short period cost reports were addressed in the RAND research and if this had an adverse effect on the research results.

Table 3: Number of IRFs with More Than One Cost Report Year End in Calendar Year

Calendar	1999	2000	2001	2002	2003	2004

Units	*43*	*14*	*27*	*13*	*24*	*3*
Hospitals	*4*	*3*	*54*	*4*	*6*	*-*
Total	***47***	***17***	***81***	***17***	***30***	***3***

d. The FAH discovered errors in the teaching facility status among its member hospitals. HCA identified three of its IRFs that were identified as teaching facilities, yet none of the three have teaching programs in their IRFs. HCA reported these errors directly to CMS.

Errors in the teaching facility assignment could distort the payment factor development for the refined IRF PPS and could impact the financial projections used by CMS in this proposed rule. The FAH strongly urges CMS to delay implementation of any IRF PPS teaching adjustment refinement until such time as CMS has validated and corrected the teaching status of all IRFs as well as resolving the cost issues that have been previously discussed.

e. The data used by CMS and RAND to determine proposed refinements to the IRF PPS was calendar year 2002 and FY 2003 (page 30192). CMS implemented the enforcement of the CMS 75% Rule on July 1, 2004. CMS acknowledges the impact of the 75% rule on page 30222, "...that IRF's cost structures may be changing as they strive to comply with other recent
Medicare policy changes, such as the criteria for IRF classification commonly known as the '75 percent rule'." Since the implementation of the 75% rule, there has been a dramatic decrease in the volume in selected Rehabilitation Impairment Groups (RIC). (5 RICs have a greater than 10 percent decline in volume.) The industry is already seeing alterations in the case mix groups, relative weights and expected lengths of stay from pre-enforcement of this rule to post-enforcement. Thus, the proposed modifications to the IRF PPS may not have the intended effect. Table 4 below shows the initial impact of the enforcement of this rule. The FAH believes that CMS and RAND did not take the impact of the 75% rule into account when proposing the FY 2006 refinement of the IRF PPS.

Table 4: Impact of 75% Rule on Volume of Cases*

RIC	[illegible]	[illegible]	[illegible] - Change	[illegible] Change
01 – Stroke	*35,228*	*35,064*	*-164*	*-0.46%*
02 – Traumatic BI	*3,304*	*3,717*	*413*	*12.50%*
03 – Nontraumatic BI	*4,853*	*5,306*	*453*	*9.33%*
04 – Traumatic SCI	*1,086*	*1,144*	*58*	*5.34%*
05 – Nontraumatic SCI	*7,641*	*7,601*	*-40*	*-0.52%*
06 – Neurological	*9,679*	*10,996*	*1,317*	*13.60%*
07 – Hip fracture	*27,171*	*27,104*	*-67*	*-0.25%*
08 – Major joint replacement	*52,947*	*47,937*	*-5,010*	*-9.46%*
09 – Other Orthopedic	*12,442*	*11,729*	*-713*	*-5.73%*

10 – Amputation, LE	*5,500*	*5,400*	*-100*	*-1.82%*
11 – Amputation, other	*555*	*387*	*-168*	*-30.27%*
12 – Osteoarthritis	*3,326*	*2,172*	*-1,154*	*-34.70%*
13 – Other arthritis	*2,240*	*1,558*	*-682*	*-30.45%*
14 – Cardiac	*13,098*	*10,643*	*-2,455*	*-18.74%*
15 – Pulmonary	*4,853*	*3,616*	*-1,237*	*-25.49%*
16 – Pain syndrome	*4,137*	*3,707*	*-430*	*-10.39%*
17 – MMT - No BI, SCI	*2,291*	*2,052*	*-239*	*-10.43%*
18 – MMT - w/BI or SCI	*549*	*550*	*1*	*0.18%*
19 – Guillain-Barre	*318*	*292*	*-26*	*-8.18%*
20 – Miscellaneous	*28,511*	*24,317*	*-4,194*	*-14.71%*
21 – Burns	*155*	*120*	*-35*	*-22.58%*
Total	***219,884***	***205,412***	***-14,472***	***-6.58%***

* *Data represents Medicare cases from the UDSMR database. The data is drawn from the 3 quarters prior to the beginning of the enforcement period and the 3 quarters immediately after the start of the enforcement period. This analysis includes 616 facilities. Each facility had at least one case every month from January 2002 through March 2005. In order to allow for new facilities, withdrawals, and data submission problems, UDSMR limited their analysis to these 616 facilities (out of 848 total facilities).*

The FAH strongly recommends that CMS implement a standard payment update for F 2006 and delay implementation of the proposed IRF PPS refinements until CMS can utilize FY 2005 data in developing and making projections for IRF PPS refinements. CMS uses recent fiscal year data in making proposed changes to the Inpatient PPS system (e.g., for FY 2006 changes, CMS used FY 2004 data.) This will allow the impact of the CMS 75% rule on casemix to stabilize somewhat (i.e., most of the facilities will be at or above the 50% compliance mark with the regulations at 42 CFR Part 412).

Also, the FAH strongly recommends that CMS not implement any refinement system, including the proposed IRF PPS refinement, until <u>all</u> necessary system changes have been made and tested.

f. The FAH has concerns related to the redistribution impact of the changes to the CMG structure that weights and LOS appear to have. In order to analyze this concern, the FAH reviewed the case mix changes indicated in the IRF-PPS impact file with the IPPS impact. This review indicated that the CMG case mix changes are significantly more redistributional than the IPPS proposed changes. Over 45% of the IRFs had a case mix change of greater than 3% compared to only 0.3% of the IPPS facilities having this same change. (See Table 3 below).

   The FAH feels that great care should be made when making changes of this magnitude. Changes to case mix of this magnitude should only be made when it will profoundly improve the system. In addition, changes of this magnitude should be transitioned if possible.

Table 5: National % Distribution of Changes > 3% in Case Mix

	IRF	***IPPS***
> 3% Increase	*31.6%*	*0.1%*

> 3% Decrease	*13.8%*	*0.2%*
Total Change > 3%	***45.5%***	***0.3%***

2. Proposed Refinements to the Patient Classification System

The FAH supports the technical comments submitted by UDSMR related to this section of the proposed IRF PPS rule.

a. Proposed Changes to the Existing List of Tier Comorbidities: On page 30195 CMS states, "The data indicate large variation in the rate of increase from the 1999 data to the 2003 data across conditions that make up the tiers. The greatest increases were for miscellaneous throat conditions and malnutrition, each of which were more than 10 times as frequent in 2003 as in 1999. The growth of these two conditions was far larger than for any other condition. Many conditions, however, more than doubled in frequency, including dialysis, cachexia, obesity, and the non-renal complications of diabetes. ... We believe that the data provided by RAND support the removal of the codes in [Table 1] below because they either have no impact on cost after controlling for their CMG or are indistinguishable from other codes or are unrealistically overrepresented. Therefore, we are proposing to remove these codes from the tier list."

The FAH encourages CMS to delay making the changes recommended to comorbidities until a complete analysis and validation of the data is conducted.

b. Proposed Changes to Move Dialysis to Tier One: CMS on page 30195 states, "We are proposing the movement of dialysis to tier one, which is the tier associated with the highest payment." The data from the RAND analysis show that patients on dialysis cost substantially more than current payments for these patients and should be moved into the highest paid tier because this would more closely align payment with the cost of a case."

The FAH supports CMS in moving dialysis to tier one. However, as stated above, we recommend that CMS not make any changes to dialysis until the representative data has been analyzed and validated as accurate.

c. Proposed Changes to Move Comorbidity Codes Based on Their Marginal Cost: CMS states on page 30196, "We believe the IRF PPS led to substantial changes in coding of comorbidities between 1999 (pre-implementation of the IRF PPS) and 2003 (post-implementation of the IRF PPS). ... Although, coding likely improved, the presence of upcoding for a higher payment may play a factor as well. The 2003 data provide a more accurate explanation of the costs that are associated with each of the comorbidities, largely due to having 100 percent of the Medicare-covered IRF cases in the later data versus slightly more than half of the cases in 1999 data. Therefore, using the 2003 data to propose to assign each diagnosis or condition will considerably improve the matching of payments to their relative costs."

The FAH agrees with CMS that IRFs began to more accurately code the ICD-9 codes on the IRF-PAI upon the implementation of IRF PPS. CMS provided extensive education in 2001 and 2002 to IRFs on the encoding of the IRF-PAI, including

education on how to encode the comorbidities into the IRF-PAI, in preparation for the transition into IRF PPS. We do not agree that using the 2003 data will improve the matching of payments to their relative costs and strongly recommend that CMS delay implementation of any changes to comorbidities until FY 2005 data is available for use by CMS and RAND.

d. Proposed Changes to the CMGs: CMS states on page 30196, ...[W]e are proposing to update the CMGs used to classify IRF patients for purposes of establishing payment amounts. We are also proposing to update the relative weights associated with the payment groups based on FY 2003 Medicare bill and patient assessment data."

   The FAH does not support the refinement of the CMGs or the weighting of the motor score index at this time. Until a comprehensive data analysis is completed and FY 2005 data is used, the FAH strongly encourages CMS to delay implementation of refinement to the IRF PPS.

3. Proposed FY 2006 Federal Prospective Payment Rates

a. Proposed Reduction of the Standard Payment Amount to Account for Coding Changes: On page 30222, CMS states, "Therefore, for FY 2006, we are proposing to reduce the standard payment amount by the lowest amount (1.9 percent) attributable to coding changes." CMS also states on page 30222, "since we feel it is crucial to maintain access to IRF care, we are soliciting comments on the effect of the proposed range of reductions on access to IRF care, particularly for patients with greater resource needs."

   CMS recognizes that the separation of total case mix change between real case mix change and coding change is difficult to determine precisely.

   "However, while the data permit RAND to observe the total change in expected costliness of patients over time with some precision, estimating the amount of this total change that is real and the amount that is due to coding generally cannot be done with the same level of precision."

   RAND used two models to determine real change in case mix and coding change. Yet, CMS acknowledged that one model "potentially underestimates the amount of real case mix change" and the other model "potentially overestimates real change".

   The FAH recommends that CMS delay implementation of the reduction in the Standard Payment Amount until a regression analysis model with a greater predictability has been developed using 2005 IRF data. Also, under TEFRA the IRFs were incentivized to keep their costs under the cap which typically means taking patients with fewer medical complications and lower lengths of stays. When PPS was implemented, CMS began paying for patients more appropriately with higher medical needs and complications. Thus, the change in incentives should have resulted in an increase in real case mix change under IRF PPS. CMS also provided extensive education on the encoding of the IRF-PAI which included appropriate coding of Items 22, 24 and 47 (ICD-9 coding). Thus, the industry has experienced more

accurate coding of the IRF-PAI. Reduction in the Standard Payment Amount along with identified data inaccuracies and the impact of the 75% rule will have a much greater impact on the IRFs than CMS intends.

CMS reduced the initial IRF PPS payment rate by a behavioral offset of 1.16%. FAH believes that CMS has adequately adjusted for any coding changes as part of the behavioral offset.

To address the access to care request for comments issue, the FAH wants to point out that the GAO projected in its April 2005 report (GAO-05-366) that only 6 percent of the IRFs will meet compliance with the 75% rule when it is fully implemented. Table 4 below, taken from the GAO report, points this out. Thus the reduction in payment along with the 75% rule will drastically limit access for beneficiaries to the IRF.

Table 5: IRFs That Met Varying Threshold Levels for Medicare Patients Admitted with Any of 13 Conditions on List in Rule in Fiscal Year 2003*

Compliance Threshold	**Percentage of IRFs that met threshold based on either primary condition or related comorbid conditions**	**Percentage of IRFs that met threshold based solely on primary condition**
50 percent	*85*	*39*
60 percent	*62*	*20*
65 percent	*50*	*14*
75 percent	*27*	*6*

* *Source: GAO analysis of CMS IRF-PAI data*

b. Proposed Market Basket Used for IRF Market Basket Index: CMS states on page 30222, "...we propose to update payments for rehabilitation facilities using a market basket reflecting the operating and capital cost structures for IRFs, IPFs, and LTCHs, hereafter referred to as the RPL (rehabilitation, psychiatric, long-term care) market basket." On page 30223 CMS states, "The proposed RPL market basket is a fixed weight, Laspeyres-type price index that is constructed in three steps. First, a base period is selected (in this case, FY 2002)..." On page 30232, CMS states, "The proposed FY 2006 update for IRF PPS using the proposed FY 2002-based RPL market basket and Global Insight's 4th quarter 2004 forecast is 3.1 percent."

   The FAH commends CMS for attempting to develop a market basket index that is more reflective of the IRF's actual costs. That being said, the FAH encourages CMS to delay implementation of a market basket update until the time when all costs as previously discussed have been accurately included in the data.

c. Labor-Related Share: CMS states on page 30233, "Thus, the labor-related share that we propose to use for IRF PPS in FY 2006 would be 75.958 percent. This proposed labor-related share is determined using the same methodology as employed in calculating all previous IRF labor-related shares (66 FR at 41357)."

   Due to concerns raised earlier in this comment letter related to rehabilitation cost the FAH strongly recommends that CMS not change the labor share for 2006.

If CMS decides to implement a change in the labor-related share the FAH recommends a transition given the very significant and unusual change (almost 5%). For transition the FAH recommends the labor-related share be based on 80% of the current labor-related share and 20% of the proposed labor-related share.

d. Proposed Area Wage Adjustment: On page 20239 CMS states, "We are proposing to adopt the new CBSA-based labor market area definitions beginning with the 2006 IRF PPS fiscal year without a transition period, without a hold harmless policy, and without an "out-commuting" adjustment. We believe that this proposed policy is appropriate because despite significant similarities between the IRF PPS and the IPPS, there are clear distinctions between the payment systems, particularly regarding wage index issues."

   The FAH agrees with CMS' proposed move to new CBSA census definitions. We believe it is logical that all prospective payment systems utilize the same census definitions. However, we recommend the change be transitioned over the period of one year. We believe the simplest way to administer this transition would be to blend the CBSA and the MSA wage indexes for all IRFs for Federal FY 2006.

e. Proposed Teaching Status Adjustment: CMS states on page 30241, "Therefore, we are proposing to establish a facility level adjustment to the Federal per discharge base rate for IRFs that are, or are part of, teaching institutions..." And on page 30243, "We would propose to implement a teaching status adjustment in such a way that total estimated aggregate payments to IRFs for FY 2006 would be the same with and without the proposed adjustment (that is, in a budget neutral manner). This is because we believe that the results of RAND's analysis of 2002 and 2003 IRF cost data suggest that additional money does not need to be added to the IRF PPS. RAND's analysis found, for example, that if all IRFs had been paid based on 100 percent of the IRF PPS payment rates throughout all of 2002 (some IRFs were still transitioning to PPS payments during 2002), PPS payments during 2002 would have been 17 percent higher than IRFs' costs.

   The FAH strongly recommends that CMS not implement a teaching adjustment at this time. This recommendation is based on our concerns noted earlier related to rehabilitation cost. We are also concerned that the current research differs so much from initial research in developing this PPS system. The initial research indicated no adjustment was needed for teaching. The proposed regulation contains a very significant teaching adjustment of 1.35% of the total PPS payments. A review of the CMS impact files indicates that the effect of this adjustment adds as much as 73% in payments to at least one hospital.

   The FAH encourages CMS to continue to research this adjustment. However, if future analysis indicates that an adjustment this large is needed we recommend that CMS transition the adjustment over several years (i.e., 4 Years).

f. Proposed Adjustment for Rural Location: On page 30244 CMS states, "...we are proposing to increase the adjustment to the Federal prospective payment amount for IRFs located in rural areas from 19.14 percent to 24.1 percent. We are proposing this change because RAND's regression analysis, using the best available data we have

(FY 2003), indicates that rural facilities now have 24.1 percent higher costs of caring for Medicare patients than urban facilities."

The FAH recommends that CMS not change the rural add-on due to our previous concerns on rehabilitation cost and the impact of enforcement of the 75% rule.

The FAH also recommends that CMS provide for a transition for hospitals moving from rural to urban under the new census definitions. Our review of CMS' Inpatient Rehabilitation Facility Wage Index file indicates that 36 facilities would lose this rural add-on of 19.1%. CMS did provide a transition when the new census definitions were applied to the IPPS system for hospitals moving from urban to rural. These changes to IRFs are generally much more significant than the IPPS facilities would experience.

The FAH recommends one of the following transitions:

- Maintain the Rural Add-on for three years. This is consistent with the IPPS decision.
- Transition to eliminate the 19.1% add-on over 4 years. Year one 15%
  Year two 10%
  Year three 5%

g. Proposed Adjustment for Disproportionate Share of Low-Income Patients: CMS states on page 30245, "We propose to update the LIP adjustment from the power of 0.438 to the power of 0.636."

The FAH recommends that CMS not change the DSH adjustment at this time. This recommendation is based on the concerns related to rehabilitation cost and the impact of the enforcement of the 75% rule.

Should CMS decide to change this adjustment the FAH recommends that CMS transition this change over several years. This is based on our review of the impact file that indicated the DSH add-on would increase from 31% to 38% for hospitals receiving this adjustment.

h. Proposed Update to the Outlier Threshold Amount: CMS states on page 30245, "...we are proposing to update the outlier threshold amount from the $11,211 threshold amount for FY 2005 to $4,911 in FY 2006 to maintain total estimated outlier payments at 3 percent of total estimated payments."

The FAH commends CMS for recommending that the outlier threshold be significantly reduced and in acknowledging that the outlier underpayment problem in 2005 is due to declining ratios of cost to charges. The FAH made extensive recommendations on the 2006 IPPS rule on how future declines in the ratio of cost to charges should be considered to avoid systematic under payment of outlier payments. For convenience we are attaching this section of the IPPS comments as well as two related studies.

The FAH recommends that CMS maintain the 3% outlier pool and reduce the threshold consistent with the adoption of one of the formulas alterations offered in the

attached comments FAH previously submitted in connection with the FY 06 IPPS proposed rule. If one of these recommendations is not implemented, the FAH recommends the outlier pool be reduced in order to reduce the underpayments in outliers.

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FAH appreciates CMS' review and careful consideration of the comments in this letter, and would be happy to meet, at your convenience, to discuss them. If you have any questions, please feel free to contact Steve Speil at 202-624-1529.

Respectfully submitted,
Charles N. Kahn III, President

Federation of American Hospitals

deemed to have been under development as of December 8, 2003, or any other specific date. The other criteria for retaining the necessary provider status for such relocated existing CAHs provide more than ample assurance that no new necessary providers will be certified after December 31, 2005.

Part IX of the NPRM

MedPAC Recommendations

Please see the FAH's comments regarding Specialty Hospitals in Section V.L. of this letter, above. Those comments are also responsive to the MedPAC recommendations.

Addendum Part II. A. 4.c.

Outliers

CMS has proposed to establish the fixed-loss cost outlier threshold for FY 2006 as the prospective payment rate for the diagnosis related group ("DRG"), plus any indirect medical education ("IME") and disproportionate share hospital ("DSH") payments, and any add-on payments for new technology, plus **$26,675**. The present threshold, which has been in effect for all of FY 2005, is $25,800. In establishing the proposed FY 2006 threshold, CMS has proposed to continue using the "charge methodology" that it began using for FY 2003, with a slight change in the methodology for projecting an increase in charges. As part of the calculation, CMS is using the 1-year average annualized rate of change in charges per case from the last quarter of FY 2003 in combination with the first quarter of FY 2004 (July 1, 2003 through December 31, 2003) to the last quarter of FY 2004 in combination with the first quarter of FY 2005 (July 1, 2004 through December 31, 2004), in order to update charges from FY 2004 to FY 2006. According to CMS, the average annualized rate of change in charges per case between these periods was 8.65 percent, or 18.04 percent for two years. Also, CMS has proposed, as has been done in the past, to use the hospital cost-to-charge ratio from the most recently-available Provider Specific File, which for FY 2006 is the December 2004 update.

CMS has proposed to establish the FY 2006 threshold using the same model as was used for FY 2005, except for a slight change in how the rate of increase in charges is estimated.[3] The FAH objected strongly in our comments last year that the model being used by CMS would severely underreimburse hospitals for their outlier payments. As with the prior year, this has turned out to be true. For FY 2004, CMS has disclosed in the proposed rule that estimated outlier payments will be 3.5%, an estimate significantly lower than the 4.4% estimate that was given based on available data in last year's

[3] For FY 2005, the estimated rate of increase in charges was determined by comparing the rate of increase in charges from the first half-year of FY 2003 to the first half-year of FY 2004.

proposed IPPS rule. This represents an aggregate underpayment of approximately $1.4 billion to hospitals nationwide. For FY 2005, CMS states:

> "We currently estimate that actual outlier payments for FY 2005 will be approximately 4.4 percent of actual total DRG payments, 0.7 percentage points lower than the 5.1 percent we projected in setting outlier policies for FY 2005."

The estimated payments of 4.4 percent, or 0.7 percentage points lower than the 5.1 percent that was set aside to pay outliers is a significant underpayment. This represents an aggregate underpayment of over $600 million. The currently estimated underpayment amounts to an approximate 16% underpayment, and, is likely to be much greater when more recent estimates are made, as occurred for FY 2004. It is clear from the experience of the past two years that CMS's methodology to project outlier payments and set the outlier thresholds is not working. The FAH urges CMS to recognize this fact and to consider altering its methodology so that more accurate projections can be made.

The FAH believes that the model that CMS has used for FYs 2004 and 2005 and has proposed to continue to use for FY 2006 fails to incorporate one extremely significant variable: the resulting decline in the cost-to-charge ratio ("RCC") that is a by-product of significant projected charge increases. The objective of the outlier model should be to project outlier costs. The present CMS model using the two year average annualized rate of change in charges per case based on two recent six month periods, but with the RCC locked as of December 2004, will fail to reasonably project outlier costs. Outlier costs are equal to charges times RCC. CMS is projecting the charges to increase for FY 2006 by 18.04% over 2 years; yet, the RCCs are locked as of December 2004. Such a model will invariably underpay outliers. The FAH urges CMS to consider alternate models, discussed herein, which should lead to a more accurate projection of outliers.

As was done in support of its comments for FY 2005, the FAH engaged Vaida Health Data Consultants ("VHDC") to model the outlier thresholds for FY 2006 using CMS's proposed 2-year charge increase model, modified to reflect the decline in the RCCs. The FAH has attached as Exhibit C to this letter a copy of the outlier study performed by VHDC for the FAH. Based upon that model, the FAH recommends that the outlier threshold for FY 2006 be set at **$24,050** or lower.

Significantly, the FAH notes that VHDC's projections for both FY 2004 and FY 2005 were considerably closer to the threshold that would have resulted in the 5.1% target being met than were the projections done by CMS for those two fiscal years. In its comments for FYs 2004 and 2005, the FAH modeled the 2-year charge increase model that was used by CMS, but recommended that CMS also model the decline in the RCCs rather than locking the RCCs in at a point in time. Using the projected decline in RCCs, VHDC's model for the outlier threshold resulted in a threshold of $25,375 for FY 2004, which was what the FAH recommended in its comments. This can be contrasted with the threshold of $31,000 that was adopted by CMS (revised downward mid-year to $30,150). As explained by CMS in this year's Proposed Rule, these thresholds resulted in outliers at the 3.5% level, representing a 34%, or $1.4 billion, underpayment. For FY 2005,

VHDC's model resulted in a threshold of $28,445, compared to the $35,085 threshold proposed by CMS (which would have been $32,510 if CMS had used the 3/31/04 HCRIS update that VHDC used). The FAH was pleased that CMS considered its comments and significantly lowered the threshold when the Final Rule was published, ultimately setting the threshold at $25,800.[4] However, as it has turned out, even this significant reduction in the threshold was not large enough. As stated in the Proposed Rule, the threshold set by CMS for FY 2005 has resulted in outlier payments being underpaid by an estimated 0.7% or 16% (and the FAH believes that the outlier underpayment will actually be greater than that).

As part of its engagement for FY 2006, VHDC modeled what the threshold should have been to pay out the 5.1% for FY 2005. VHDC estimates that the threshold should have been $21,925 for FY 2005 using the cost to charge ratios from the CMS impact file. When the model is adjusted to reflect the updates that will occur to the RCCs for the remainder of FY 2005, VHDC estimates the threshold for FY 2005 should have been even lower, or $21,640 (as compared to the $25,800 threshold set by CMS), in order to reach the 5.1% target. For FY 2004, using the latest data available, VHDC estimates the threshold should have been $21,555 (as compared to the $31,000/$30,050 thresholds set by CMS), in order to reach the 5.1% target.

For FY 2006, VHDC, as explained in detail in the attached report (Exhibit C), estimated what the fixed loss amounts should be, using the same "charge methodology" used by CMS in its projections. VHDC ran several projections to demonstrate the impact of factors that should be taken into account but were omitted from CMS's projection methodology. First, VHDC ran a projection using the most recent (3/31/2005) HCRIS update. This resulted in an estimated fixed loss amount of **$25,085** (compared to the $26,675 fixed loss amount projected by CMS). Second, VHDC ran a projection that took into account the decline in RCCs that will occur before outliers are actually calculated during FY 2006. The decline in RCCs was projected from the most recent RCC data in the 3/31/2005 HCRIS update to the fiscal periods expected to be used for the calculation of the RCCs determining outlier payments during FY 2006. The projected decrease in RCCs was calculated using the CMS charge inflation factor of 8.65% and the 2001-2003 aggregate annual rate of increase in cost per discharge, calculated by VHDC to be 6.57%. This second projection, taking into account the key factor of updating RCCs, resulted in an estimated fixed loss amount of **$24,050**. Based upon the analysis performed by

[4] The lower threshold published in the Final Rule for FY 2005 resulted from CMS's modification of how it projected the two year increase in charges, as described above. This also impacted the level of the threshold proposed by the FAH. In developing the recommendation of $28,445, the FAH used the CMS estimated charge increase contained in the Proposed Rule of 14.5083% per year for two years. Then, in the Final Rule, CMS significantly revised the estimated charge increase downward to 8.9772% per year. As the FAH had pointed out in its comments last year, a drop in the estimated charge increase would significantly impact the threshold. The FAH's proposed threshold would have been considerably lower if it was working with the charge increase estimate that CMS used in the Final Rule.

VHDC, the FAH recommends that CMS set the outlier threshold at **$24,050** or lower for FY 2006.

As stated previously, the objective of the outlier model should be to reasonably project outlier costs. Thus, as the FAH did for its FY 2005 comments, it also asked VHDC to estimate the fixed loss threshold using the "cost methodology," rather than the "charge methodology." This method uses the most recent cost data available, and projects costs to FY 2006 using the cost inflation factor of 6.57% derived from HCRIS data for 2001, 2002 and 2003. CMS started utilizing the 2-year charge increase model beginning in FY 2003, largely due to the lack of timely cost report data resulting from the delay in filing of cost reports after the implementation of outpatient PPS. Prior to FY 2003, for FFYs 1994-2002, CMS utilized the cost model to project the outlier threshold. Without the timely cost report data for FY 2003, CMS was unable to continue to utilize the cost model for FY 2003. Now that the backlog in filing and processing of Medicare cost reports caused by the implementation of outpatient PPS has been resolved, this methodology could be considered again.

Using data from the recent 3/31/2005 HCRIS Update, VHDC ran projections using the cost methodology, which resulted in an estimated fixed loss threshold for FY 2006 of **$22,520**. The FAH notes that its projections using the cost methodology resulted in a threshold for FY 2005 that was much closer to the threshold that would have resulted in payment of 5.1% outliers than either CMS's charge methodology or the FAH's charge methodology adjusted for the projected decrease in RCCs. For FY 2005, the FAH's projection using the cost methodology resulted in a threshold of $22,830; based on the most recent data, an accurate threshold for FY 2005 would have been $21,640.

We have also retroactively projected an estimate for FY 2004 using the cost methodology, based on data that was available in mid-2003.[5] VHDC has calculated that a projection using the cost methodology would have resulted in a threshold of $20,900, compared to a threshold of $21,555 that would have resulted in the 5.1% target. The VHDC report explaining how these calculations were done is attached as Exhibit D.

To make this easier to understand, the data for these various projections is arrayed in the following table:

[5] When commenting on the Proposed Rule for FY 2004, the FAH did not project the outlier threshold based on the cost methodology. However, VDHC is able to do so now, based on the data that would have been available in June 2003, at the time that outlier thresholds were being set for FY 2004.

FY	CMS Threshold	CMS Est. Actual Pmt	FAH Recommended Outlier Models: Cost Model	FAH Recommended Outlier Models: RCC Inflation Model	FAH Recommended Outlier Models: Threshold to Pay 5.1%
2004	$31,000	3.5%	$20,900	$25,375	$21,555
2005	$25,800	4.4%	$22,830	$28,445	$21,640

As evidenced by these calculations, the estimates using the cost methodology would have been much more accurate projections than the estimates resulting from the "charge" methodology used by CMS or even than the modified "charge" methodology suggested by the FAH. While the cost methodology would have slightly under-projected the outlier threshold for FY 2004 and slightly over- projected the threshold for FY 2005, some reasonable variation should be expected from the most accurate of outlier payment models. It is unrealistic to expect to precisely hit the 5.1% payout each year. However, it is not appropriate to use a model that will invariably underpay the 5.1%, as the FAH believes the proposed CMS model will do. The cost methodology for FY 2004 and FY 2005 would have produced a more reasonable result.

CMS is to be commended for the changes made to the outlier payment methodology in 2003 to eliminate the use of the statewide average for hospitals with low RCCs, to adopt the use of the most recent settled cost report to adjust the RCC, and to require the more timely update of the RCCs. While in the several years prior to FY 2003 the use of the cost methodology was resulting in outlier payments exceeding the 5.1% target, FAH believes that the corrective actions taken by CMS in 2003 significantly strengthen the predictability of the cost methodology Such excess payments prior to 2003 should not be attributed to the cost methodology, but should more likely be attributed to the untimely update of the RCCs and to the use of the statewide average for hospitals with extremely low cost-to-charge ratios.

Because the cost methodology, as shown herein, has proved to be a more accurate predictor in the past couple of years, the FAH recommends that CMS return to the use of the cost methodology for the projection of outlier payments. The fixed loss outlier threshold should be **$22,520**, using the cost methodology.

The FAH also suggests that CMS consider making mid-year adjustments to the outlier thresholds, if it appears that outlier payments are going to be significantly below or above the 5.1% target. As CMS made a mid-year change to the fixed loss threshold in FY 2004, it clearly has the ability to do so. After the fiscal year has begun, more current data on hospitals' cost-to-charge ratios will be available, so it should be possible to more accurately predict the amount of outlier payments that will be made. CMS could set a trigger for this adjustment. For example, if outlier payments appeared to be coming out at less than 95% or more than 105% of the 5.1% target, an adjustment would be made. The large discrepancies between outlier payments made and the 5.1% target, both

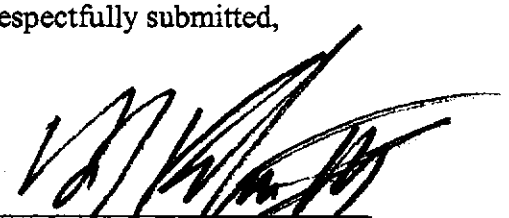
positive and negative, that have occurred over the years could possibly be avoided if CMS tracked the situation mid-year and made an adjustment to the threshold with the goal of hitting the 5.1% target overall for the year. The FAH believes that a mid-year correction process could be an aid to CMS to achieve its goal of making outlier payments at 5.1% irrespective of the payment model that CMS employs. However, we believe there will likely be less need for a mid-year correction process if CMS were to adopt either of the two payment models that we have recommended in these comments, i.e., the cost methodology model or the CMS model modified to reflect the decline in the RCCs.

In summary, the FAH is extremely concerned with the continued use of the present CMS model that has proven to significantly underpay hospitals for outliers for FY 2004 and FY 2005. The CMS model does account for charge increases but fails to account for cost increases. Such a model will invariably continue to significantly under-reimburse hospitals for patient care services rendered to Medicare patients that become outliers. FAH recommends that CMS either adopt the cost methodology that it used prior to FY 2003 or, in the alternative, adopt the model recommended by the FAH that adjusts for both charge and cost increases in computing the RCCs.

* * * *

FAH appreciates CMS's review and careful consideration of the comments in this letter, and would be happy to meet, at your convenience, to discuss them. If you have any questions, please feel free to contact Steve Speil, SVP, CFO at 202-624-1529.

Respectfully submitted,



Charles N. Kahn III, President
Federation of American Hospitals

EXHIBIT C

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June 14, 2005

MODELING FFY 2006 OUTLIER PAYMENTS

DATA SOURCES.

1. The MEDPAR 2004 computer file obtained from CMS. The file contains 13,610,386 records, each corresponding to a Medicare hospital discharge occurring in FFY 2004.

2. CMS FFY 2006 Impact File (Proposed Rule Version). This file produced by CMS shows the estimated level of FFY 2006 outlier payments by hospital (as percentages). It also shows the hospital-specific parameters used for calculating PPS payments, such as DSH and IME adjustment factors, cost to charge ratios (CCRs), wage indexes, etc.

3. The March 31, 2005 update of the HCRIS database. This database consists of Medicare cost reports beginning in Federal Fiscal Years (FFYs) 1996 through 2004.

REPLICATION OF THE CMS ESTIMATED 2006 OUTLIER PAYMENT LEVELS (IPPS PROPOSED RULE OF MAY 4).

The regular and outlier FFY 2006 payments were estimated for each patient in the MEDPAR database. Regular payments were calculated based on the proposed DRG weight, the patient discharge destination (for identifying transfers), the applicable proposed standardized amounts and the other hospital-specific parameters determining PPS payments. The latter are the wage index, the non-labor cost of living adjustment, and the DSH and IME adjustment factors. Each of these parameters has different values applicable to operating and capital payments. The parameters were obtained from the CMS Impact File.

Outlier payments were calculated inflating 2004 charges by 18.04 percent (the inflation factor used by CMS), reducing charges to costs using the cost to charge ratios from the CMS Impact File and comparing costs to the proposed FFY 2006 fixed loss amount of $26,675. The latter was adjusted as appropriate on a hospital-specific basis. It should be noted that the Impact File cost to charge ratios are mostly from fiscal periods beginning in FFY 2003. Also, no allowance was made for the anticipated continued decrease in the CCRs.

With these assumptions, both the FFY 2006 operating and capital outlier payments were estimated at 5.02 percent of the respective total payments, net of DSH and IME amounts. In the case of operating payments the result is slightly lower than the Proposed Rule CMS estimate of 5.10 percent. Interestingly, the published CMS estimates do not agree entirely with the CMS Impact File. Using the Impact File CMS individual hospital outlier percentages and calculating DRG payments from other Impact File data, the operating outlier level is 5.01 percent and the capital level is 5.08 percent. At least in the case of operating payments, the CMS Impact File result is very close to the MEDPAR-based estimate. In any event, these differences are not particularly significant. Most likely, they originate from different estimates being based on different stages of completeness of the MEDPAR file. The dollar amount of FFY 2006 outlier payments was estimated at $4,340B.

ESTIMATE OF THE FFY 2006 FIXED LOSS AMOUNT USING THE MOST RECENT COST TO CHARGE RATIOS.

More recent cost to charge ratios were calculated from the latest cost reports available in the HCRIS database. Medicare inpatient operating costs were obtained from Worksheet D-1, Part II, Medicare inpatient capital costs from Worksheet D, Parts I and II and Medicare inpatient charges from Worksheet D-4. A comparison with the dates of the CCRs in the Impact File, presumably used to establish the proposed FFY 2006 fixed loss threshold, is shown in the table below.

Beginning in FFY	Number of Cost Reports Used for the Impact File CCRs	Percent of Cost Reports Used for the Impact File CCRs	Number of HCRIS Latest Cost Reports for Impact File Hospitals	Percent of HCRIS Latest Cost Reports for Impact File Hospitals
	(a)	(b)	(c)	(d)
2000	12	0.4%	4	0.1%
2001	18	0.6%	3	0.1%
2002	562	19.5%	91	2.5%
2003	2,271	78.7%	3,057	83.0%
2004	23	0.8%	526	14.3%
Unknown/Not Matching	807		12	
Total	3,693		3,693	

Table Notes: Column (a) numbers are based on matching Impact File CCRs with HCRIS CCRs for fiscal periods beginning between 2000 and 2004. If both operating and capital CCRs were within 0.001 of their respective counterparts, the HCRIS cost report was considered to be the source for the Impact File CCR. Percentages in columns (b) and (c) are based on the total of FFYs 2000-2004, i.e., unkown/not matching hospitals were not included.

Using the more recent HCRIS CCRs and the CMS assumptions listed above, the estimate of the fixed loss threshold is **$25,085**, significantly lower than the proposed value.

ESTIMATE OF THE FFY 2006 FIXED LOSS AMOUNT PROJECTING BOTH CHARGE AND COST INFLATION.

Outlier payments are calculated from costs. Costs are determined by applying a cost to charge ratio to actual charges. It follows that accurate outlier estimates require projecting **both** costs and charges. An additional complication is the inevitable lag between CCRs that can only be determined retrospectively at the end of an elapsed cost reporting period and the current charges to which they

are applied. Historically, CMS has projected outlier payments by projecting only costs or only charges and ignored the time lag problem. This approach works well in periods when cost and charges move more or less in tandem. When costs and charges change at significantly different rates, relying on only one measure of inflation can result in either outlier over- or underpayments[1]. An alternative methodology that overcomes these shortcomings is described below.

In order to account for the time lag problem, cost to charge ratios were projected from the most recent fiscal period in the March 31, 2005 HCRIS update to the fiscal period(s) expected to be used for the calculation of the CCR(s) determining FFY 2006 outlier payments. The CMS Program Memorandum A-03-058 dated July 3, 2003 instructs Fiscal Intermediaries to update the CCRs "not later than 45 days after the date of the tentative settlement or final settlement used in calculating the CCRs". Combining this deadline with the maximum of eight months between the end of the cost reporting period and tentative settlement, it is reasonable to expect CCRs to be updated no later than nine months after the end of the cost reporting periods. Assuming a nine-month lag in updating CCRs, FFY 2006 outlier payments will be based partly on 2004 and partly on 2005 ratios, depending on the fiscal period ending date (FPE). Hospitals with a January FPE will have their CCR updated to the FPE January 2005 by October 31, 2005. Their FFY 2006 outlier payments will be based on the FPE January 2004 CCR for one month (October 2005) and on the FPE January 2005 CCR for the remaining eleven months. Similarly, FFY 2006 outlier payments for hospitals with a February FPE will be based on the 2004 CCR for two months and the 2005 CCR for ten months, and so on. Hospitals with a December FPE would have their FFY 2006 outlier payments based entirely on the FPE December 2004 CCR.

The cost inflation factor for projecting CCRs was determined from the costs reports of a cohort of 3,756 matched hospitals for periods beginning in FFYs 2001, 2002 and 2003. All three costs reports were available for each hospital from the recent update of HCRIS. The 2001-2003 aggregate annual rate of increase in the cost per discharge for these hospitals was 6.57 percent[2]. This cost inflation factor and the CMS charge inflation factor of 8.65 percent were used to project cost to charge ratios over the time periods described above. The projected CCRs were applied to projected FFY 2006 charges to simulate the determination of costs for FFY 2006 outlier payments. The estimated fixed loss amount that would result in 5.1 percent outlier payments in this scenario is **$24,050**. It should be noted that this model (as well as all the ones discussed here) does not take into account the potential impact of outlier reconciliation. The model assumes FFY 2006 outlier payments based on costs determined using pre-2006 CCRs. If outlier payments were adjusted retrospectively based on FFY 2006 "true" costs determined using 2006 CCRs, final outlier payments would be lower (assuming a continuing trend of decreasing cost to charge ratios).

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1 Of course, regardless of methodology, over- or under estimates of outlier payments may result from cost and/or charge inflation projections -usually based on the assumption that historical values are a reasonable indicator of future trends- that turn out to be inaccurate.

2 An audit adjustment was applied to costs from "as submitted" cost reports. The audit adjustment was determined by comparing 1,881 "as submitted" cost reports from the December 31, 2003 HCRIS database with the settled reports of the same hospitals in the March 31, 2005 HCRIS update.

ESTIMATE OF THE FFY 2006 FIXED LOSS AMOUNT PROJECTING ONLY COST INFLATION.

This is the methodology CMS used for the FFYs 1994-2002. For projecting FFY 2006 outlier payments, it consists of applying historical CCRs to FFY 2004 charges to determine FFY 2004 costs. These costs are projected forward to FFY 2006 using a cost inflation factor. However, the "cost inflation only" approach ignores the time lag problem. This may result in underestimating FFY 2006 costs for outlier payment determination and, therefore, underestimating the FFY 2006 fixed loss threshold. The underestimate results from using historical CCRs generally more recent than the CCRs actually available in 2004[3]. However, as discussed above, this model ignores the potential impact of outlier reconciliation. If FFY 2006 outlier payments were determined retrospectively from "true" FFY 2006 costs, the use of CCRs yielding FFY 2004 costs closer to the "true" costs is likely to result in a more accurate estimate of the FFY 2006 fixed loss amount.

The cost inflation approach using an annual cost inflation factor of 6.57 percent and the Impact File CCRs resulted in a FFY 2006 estimated fixed loss amount of **$23,610**. If the most recent CCRs from the HCRIS database were used instead, the estimated FFY 2006 fixed loss amount was **$22,520**.

ESTIMATE OF THE FFY 2005 OUTLIER PAYMENTS

The May 4 IPPS proposed rule states that FFY 2005 outlier payments are now estimated at 4.4 percent of total DRG payments. Using the "charge inflation only" model and the Impact File cost to charge ratios, the outlier payment level was estimated at 4.3 percent, essentially replicating the CMS finding. Using the same model, the fixed loss amount that would result in a payment level of 5.1 percent was estimated at **$21,925**.

The FFY 2005 fixed loss amount was estimated using all the other models described above. Still using the "charge inflation only" but substituting the most recent HCRIS CCRs for the Impact File ratios, the fixed loss threshold was estimated at **$21,710**. It should be noted that the most recent CCRs used in these model were selected by taking into account their applicability to FFY 2005. For example, assuming a nine-month lag in updating CCRs, hospitals with fiscal periods ending in June 2004 had their first six months of FFY 2005 outlier payments based on the June 2003 FPE cost to charge ratio, and the last six months based on the June 2004 FPE ratio. Even the June 2004 FPE ratio is the most recent ratio available, the CCR used in this model was an average of the 2003 and 2004 ratios weighted by the number of months of usage in FFY 2005.

If both cost and charge inflation are taken into account, and assuming a nine-month lag in updating CCRs, the FFY 2005 fixed loss threshold amount was estimated at **$21,640**.

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3 This discussion assumes charges increasing at a faster pace than costs. In that case, because FFY 2006 "costs for outlier payment determination" are obtained by applying CCRs from earlier periods to FFY 2006 charges, 2004 "costs" should be determined with similarly lagged CCRs.

Using the "cost inflation only" models the fixed loss amounts were estimated at **$20,745** and **$20,535**, based on Impact File and most recent HCRIS cost to charge ratios, respectively. Because of the problems with the "cost inflation only" model noted for the FFY 2006 estimates, i.e. not taking into account the lag in updating CCRs, it is quite likely these amounts are underestimated.

Both FFY 2005 and 2006 results and underlying assumptions are summarized in the tables on the following pages.

FFY 2006 ESTIMATED FIXED LOSS AMOUNTS AND UNDERLYING ASSUMPTIONS

METHODOLOGY	Data Source for Cost to Charge Ratios	Charge Inflation (2003-2004 MEDPAR, From Proposed Rule	Cost Inflation	Change In Cost to Charge Ratios	Assumed Lag Between the Fiscal Period End and Effective Date of the CCRs	ESTIMATED FFY 2006 FIXED LOSS AMOUNT ($)
		(Per Year)	(Per Year)	(Per Year)		
Charges Projected From FFY 2004 to FFY 2006	CMS Impact File-Proposed FY 2006	8.65%	None	None	None	26,675
Charges Projected From FFY 2004 to FFY 2006	HCRIS 03/31/2005 Update	8.65%	None	None	None	25,085
Charges Projected From FFY 2004 to FFY 2006; Cost to Charge Ratios Projected to Simulate Effective CCRs for FFY 2006 Outlier Payments	HCRIS 03/31/2005 Update	8.65%	6.57% (From HCRIS Cost Reports 2001-2003)	-1.91%	Nine Months	24,050
Costs Projected From FFY 2004 to FFY 2006	CMS Impact File-Proposed FY 2006	None	6.57% (From HCRIS Cost Reports 2001-2003)	None	None	23,610
Costs Projected From FFY 2004 to FFY 2006	HCRIS 03/31/2005 Update	None	6.57% (From HCRIS Cost Reports 2001-2003)	None	None	22,520

FFY 2005 ESTIMATED FIXED LOSS AMOUNTS AND UNDERLYING ASSUMPTIONS

METHODOLOGY	Data Source for Cost to Charge Ratios	Charge Inflation (2003-2004 MEDPAR, From Proposed Rule)	Cost Inflation	Change in Cost to Charge Ratios	Assumed Lag Between the Fiscal Period End and Effective Date of the CCRs	ESTIMATED FFY 2005 FIXED LOSS AMOUNT ($)
		(Per Year)	(Per Year)	(Per Year)		
Charges Projected From FFY 2004 to FFY 2005	CMS Impact File-Proposed FY 2006	8.65%	None	None	None	21,925
Charges Projected From FFY 2004 to FFY 2005	HCRIS 03/31/2005 Update	8.65%	None	None	None	21,710
Charges Projected From FFY 2004 to FFY 2005; Cost to Charge Ratios Projected to Simulate Effective CCRs for FFY 2005 Outlier Payments	HCRIS 03/31/2005 Update	8.65%	6.57% (From HCRIS Cost Reports 2001-2003)	-1.91%	Nine Months	21,640
Costs Projected From FFY 2004 to FFY 2005	CMS Impact File-Proposed FY 2006	None	6.57% (From HCRIS Cost Reports 2001-2003)	None	None	20,745
Costs Projected From FFY 2004 to FFY 2005	HCRIS 03/31/2005 Update	None	6.57% (From HCRIS Cost Reports 2001-2003)	None	None	20,535

EXHIBIT D

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June 21, 2005

CALCULATION OF THE FFY 2004 FIXED LOSS AMOUNT THAT WOULD HAVE RESULTED IN OUTLIER PAYMENTS OF 5.1 PERCENT

The level of outlier payments actually made in 2004 can be determined from the 2004 MEDPAR data. The operating outlier payment, if any, is explicitly shown for each Medicare discharge. The regular DRG operating payment can be easily determined from data in the file. Specifically, the operating payment net of indirect medical and disproportionate share adjustments is the DRG PRICE less CAPITAL, DSH and IME payments. The amounts shown in capitals are all fields in the MEDPAR records. The total outlier payments made in 2004 amounted to 2.679B. This represents 3.4 percent of total Medicare IPPS payments net of indirect medical and disproportionate share adjustments. The result is slightly different from the CMS estimate of 3.5 percent. The difference is not significant and may be due to the different degrees of completeness of the MEDPAR file used for the two calculations.

The outlier amounts that should have been paid could be calculated from the MEDPAR data if the cost to charge ratios actually used were available. To my knowledge there is no public data source for them. An alternative would be to estimate the CCRs from other data sources, e.g., HCRIS. However, this would involve assumptions about the rates of cost and charge inflation. In order to avoid dependence on such assumptions the CCRs were estimated from the MEDPAR file itself. The comparison of any two outlier payments *calculated using the same CCRs* allows the determination of the CCR:

$O_1 = 0.8 \times (OPCCR \times C_1 - D_1 - AFL)$

$O_2 = 0.8 \times (OPCCR \times C_2 - D_2 - AFL)$

where O = outlier payment, C = charges, D = DRG payment, AFL = adjusted fixed loss amount and OPCCR = operating cost to charge ratio.

Note that AFL is actually dependent of the cost to charge ratios, but since it cancels out of the final equation, this fact can be ignored

Adding up the two equations and solving for OPCCR:

$$OPCCR = [(O_2 - O_1) / 0.8 + (D_2 - D_1)] / (C_2 - C_1)$$

A similar calculation can be carried out for the capital cost to charge ratio. This method was used to determine the CCRs by arraying all outlier payments made to a hospital during a given quarter in increasing order of the covered charges. The calculation shown above was performed by comparing each outlier payment in the array to the outlier payment with the highest covered charges and, again, to the outlier payment with the lowest charges. The median of the CCRs thus obtained was considered to have been the CCR used to determine outlier payments for the quarter and hospital under consideration. If the actual CCR remained the same during the entire quarter, the method

above should in principle determine it exactly. If the CCR did change during the quarter, the

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Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1290-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue
Washington, DC 20201

July 14, 2005

Re: Inpatient Rehabilitation Facility Prospective Payment System,
FY2006 Proposed Rule
Federal Register Dated May 25, 2005

University of Michigan Health System (UMHS) appreciates the opportunity to comment on the proposed rule for inpatient rehabilitation facility PPS (IRF PPS).

We are writing to offer our strong support for the proposed teaching adjustment.

UMHS operates a major academic medical center, including one of the preeminent teaching hospitals in the country. Among its many highly regarded programs, is a 32-bed inpatient rehabilitation facility, which qualifies as a distinct part unit under the Medicare program. The UMHS Rehabilitation Unit is one of 16 model Spinal Cord Injury Centers in the country funded by NIDRR. In addition, acute medical rehabilitation is provided to patients with traumatic brain injury, multiple trauma, organ transplants and other debilitating diseases requiring rehabilitation. We frequently accept patients from other area hospitals that lack the sophistication to manage complex diagnoses.

The UMHS Department of Physical Medicine and Rehabilitation is noted for its outstanding teaching programs. The department has 18 residents that rotate through the clinical services, including rotations in the inpatient unit (which are excluded from the medical/surgical IME resident count).

Under the existing IRF PPS, UMHS has suffered losses, which we attribute to the lack of a teaching adjustment. In 2004, PPS payments were only 88% of inpatient cost. Prior to the PPS, UMHS' consistently earned bonus payments for maintaining its costs below its TEFRA target, which is indicative of our efforts to operate an efficient unit. A teaching adjustment is necessary to provide an appropriate level of payment to an efficiently run facility.

Since the beginning of the IRF PPS there has been a disparity in the payment equity for teaching facilities. This was demonstrated in the financial impact table accompanying the initial IRF PPS final rule. The analyses conducted by the RAND Corporation (RAND) using 2003 data show that this inequity is continuing. As their analyses demonstrated, teaching rehabilitation facilities have

higher costs than their non-teaching counterparts and these higher costs are associated with their teaching status. Consequently, without an adjustment, they will continue to fare worse under a national average payment system.

RAND's results are not surprising -- clinical operations are inherently more costly when teaching and training is involved and facilities with larger teaching programs generally treat more costly patient populations. Such a finding has been borne out in both the inpatient and psychiatric prospective payment systems, both of which include a teaching adjustment.

In the proposed rule preamble discussion, CMS expresses some concern about including a teaching adjustment, noting that RAND's analyses involved only a single year of data (2003) and that RAND did not find a statistically-significant teaching affect when it did its original analyses in [2000]. We believe such concerns are unfounded and do not warrant overriding RAND's statistically valid findings. RAND's original analyses were based on pre-PPS (1999) data from only a sample of hospitals, of which major teaching hospitals were under-represented. By contrast, their current analyses were based on post-PPS (2003) data, representing the universe of Medicare IRF cases. As CMS noted "this larger file enables RAND to obtain greater precision in their analysis and ensures a more balanced and complete picture of patients under the IRF PPS".

Because 90% of the rehabilitation facilities do not have graduate medical education programs, it is likely that CMS will field many concerns about the redistributive effects of the teaching adjustment. However, the paramount consideration should be creating a level playing field for all providers. Accordingly, a relatively small redistribution of Medicare funds to the institutions incurring the higher costs should not be an issue. The concepts of designing systems based on empirical data and payment equity should prevail.

In summary, we urge CMS to adopt the proposed teaching adjustment in its final rule for FY2006.

Thank you for the opportunity to respond to the Proposed Rule. If you have any questions about our comments or desire additional information, please call me at (734) 936-7990.

Sincerely,

Thomas Marks, Director
Accounting and Reimbursement Services
University of Michigan Hospitals and Health Centers

12

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

July 18, 2005

Mark B. McClellan, M.D., Ph.D
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1290-P
P.O. Box 8010
Baltimore, MD 21244-8010

RE: CMS 1290-P — Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for FY 2006, Proposed Rule

Dear Dr. McClellan:

In response to the proposed rule for the inpatient rehabilitation facility (IRF) prospective payment system (PPS) for Federal fiscal year (FY) 2006, the California Hospital Association (CHA) respectfully submits comments on behalf of its nearly 500 hospital and health system members. In addition to these comments, CHA supports the comments and recommendations of the American Hospital Association and the California Rehabilitation Association.

The Centers for Medicare & Medicaid Services (CMS) is proposing major changes in Case Mix Groups (CMGs), definitions, relative weights and target length of stay. An analysis of the proposed changes indicates the relative weights for stroke and traumatic brain injury would decrease more than the relative weights for other impairment groups, thereby further restricting access. It is difficult to determine the potential impact; however, if CMGs are re-weighted as proposed, providers would receive lower payments for conditions for which they have historically received adequate reimbursement. CHA is concerned that implementation of this proposal may further restrict access to IRFs. We recommend that major changes such as these be phased in over a period of time to help ensure that the community receives continued access to critically needed care and safe discharges.

Adjustment for Teaching Facilities

RAND Corporation's analysis of refined and updated IRF operating costs determined that the cost of patient care in a teaching IRF is 17 percent higher than the costs incurred in a non-teaching IRF. In an effort to account for the higher indirect operating cost of graduate medical education, CMS proposes adopting a new teaching status adjustment in a budget neutral manner. For purposes of calculating the adjustment, CMS also proposes imposing a cap on the number of full-time equivalent (FTE) residents that may be allocated to the IRF. The requirement to report

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the FTE count of Physical Medicine and Rehabilitation Residents/Average Daily Census is difficult to accurately track. Although CHA supports the need for an adjustment for teaching facilities, we recommend that CMS consider implementing a simplified method to track time, such as a total percentage of time on unit.

Outlier Threshold Amount
For cases with unusually high costs, CMS proposes substantially reducing the outlier threshold to $4,911 from $11,211. According to CMS, the proposed reduction would have the effect of making it easier for more cases to qualify for outlier payments cases with unsually high costs. CHA is concerned that the increased percentage of outlier cases and payments may unfairly and non-uniformly prompt increased probe audits from the fiscal intermediaries (FIs). CHA recommends that CMS direct FIs to modify their probes and to target audit screens to accommodate a higher percentage of outliers.

In closing, CHA reiterates that changing most of the factors in the IRF PPS for FY 2006 — all at the same time — may create uncertainty and potentially damage the rehabilitation industry, which is already at risk, further restricting access. CHA strongly urges CMS to consider phasing in the proposed changes over a specified period of time. This approach would provide IRFs the opportunity to assess the impact to access.

Thank you for the opportunity to provide comments on this proposed rule. If you have any questions or would like to discuss our comments, please contact Margot Holloway at (202) 488-4688 or mholloway@calhealth.org, or Judy Citko at (916) 552-7573 or jcitko@calhealth.org

Sincerely,

Margot Holloway
Vice President, Federal Regulatory Affairs

Judy Citko
Vice President, Continuing Care Services

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American Medical Rehabilitation Providers Association

Felice Loverso, Ph.D.
Casa Colina Centers for Rehabilitation
AMRPA Chairman of the Board

July 15, 2005

Mark McClellan, M.D. PhD
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services
Attention: CMS-1290-P
P.O. Box 8010
Baltimore, MD 21244-8010

cc: 445-G Hubert H. Humphrey Building
200 Independence Ave. S.W.
Washington, DC 20201

Ref: CMS – 1290-P, 70 F. R. 30188, May 25, 2005, "Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for FY 2006, Proposed Rule"

Dear Dr. McClellan:

This letter is submitted on behalf of the American Medical Rehabilitation Providers Association (AMRPA). AMRPA is the national voluntary trade association which represents over 400 freestanding rehabilitation hospitals, rehabilitation units of general hospitals, and a number of outpatient rehabilitation facilities. Most, if not all, of our members are participating providers in the Medicare program. Rehabilitation facilities serve over 500,000 Medicare beneficiaries per year. Medicare represents, on average, over 60% of their revenues. Hence any change in the Medicare payment system will have dramatic implications for these providers.

I. IMPLEMENTATION OF THE PROPOSED IRF PPS REFINEMENTS IN A POST 75% RULE ENVIRONMENT

On pg. 30222, in the discussion regarding the proposed reduction in the standard payment amount for coding, CMS raises concern about the impact of that change and any potential impact on access. It also acknowledges that the current cost structures of inpatient rehabilitation facilities (IRFs) may be changing as they try to comply with implementation of the 75% rule effective for cost reports beginning on or after July 1, 2004 as published in the May 7, 2004 Federal Register, "*Changes to the Criteria for Being Classified as an Inpatient Rehabilitation Facility*".

We commend CMS for recognizing these concerns and changes in the IRF environment.

We believe that the rule is having, and will continue to have, a drastic impact on the IRF field far beyond CMS's original estimates or intent. With the end of the first quarter of 2005 (the third quarter under the new 75% rule) the actual volume of Medicare patients in rehabilitation hospitals and units is down 5.8% from the same three quarters in 2003 and 2004. The drop in Medicare discharges from the second quarter of 2004 to the second quarter of 2005 is slightly over 17%. The drop for the first year of operation of the rule for Medicare beneficiaries only is 9% of discharges. We think that the ultimate impact on the field using 2002 as a base year will be a reduction in Medicare payments of $506,704,806 in FY 2006 alone and a turning away of 66,283 Medicare patients in FY 2006. See Attachment A (Analysis of Conditional Criteria) which uses an analytical model based on the text of the rule.

In so doing, the case mix of facilities will continue to change as it already has started to change, reversing the noted increases in joint replacement cases and decline in the percentage of stroke cases, among others. Eliminating care for these shorter stay, less costly patients and taking longer, stay more complex patients, along with closing beds (assuming a full substitution of cases cannot be found) will result in a change in facilities' cost structure. Hence, by October 1, 2005 when these changes are proposed to become effective they will be applied to a patient and cost environment very different and more volatile from that which was observed and upon which the research recommendations and subsequent policy recommendations were made. Another factor affecting the volatile IRF environment is the influence of various Local Coverage Decisions.

CMS notes it believes that if all facilities went initially to 100% IRF PPS payments that they would have been paid 17% over cost. We are concerned that implementing this rule into this new environment would not only eliminate all of this alleged margin but also pay for some cases below cost.

We recommend that CMS delay a broad refinement to the IRF-PPS until more current data is collected and analyzed.

We recommend that CMS engage the RAND Corporation to conduct additional analyses using, preferably, Calendar 2005 data and reconvene the Technical Expert Panel (TEP) to examine these findings and then reissue the rule. Information from this period would capture, at least, the initial compliance periods under the 75% rule for a large number of facilities. While these analyses are being conducted, CMS could still take several steps to update the IRF-PPS. They include:

1. Move forward with the annual update using the full market basket;
2. Rebase and revise the excluded market basket, subject to our recommendations below;
3. Move to CBSAs from MSAs, subject to the recommendations below; and
4. Continue to refine the proposal for an teaching adjustment which we support.

If CMS does not collect CY 2005 data and revise the proposed refinements, our comments on the proposed changes follow.

II. DATA

We note that throughout the discussion there are references to analyses done on 2003 data. However, several of the RAND reports made available were done on 2002 data. In addition, neither the RAND reports nor the rule shows the analysis of the weights and length of stay using the 2002 data or how these were obtained using the 2003 data. Such data tables were included in prior RAND reports, such as the "*Analyses for the Initial Implementation of Medicare's Inpatient Rehabilitation Prospective Payment System*" distributed to the TEP and made available by CMS in 2001 and 2002.

In order to make truly informed recommendations, particularly for the CMGs, weights and length of stay, we would like to have access to the 2002, and 2003 claims and cost report data. We are also concerned that several members noted serious problems with their provider numbers being incorrect in Table 3, which seriously affects their current and future geographic designation and wage index. Other members are concerned because the Rate Setting File with provider numbers does not show them as teaching facilities. Finally, we are concerned that the cost reports used may understate total IRF costs by an amount that would affect the final analyses.

We recommend that CMS provide the missing and requested data to the inpatient rehabilitation field so that it can make a complete assessment of how the proposed changes were derived and their impact. Until then, we recommend that CMS not issue a final rule; or, if CMS feels compelled to issue a final rule, that it be issued in interim final form with the data in question and with comments requested.

III. PATIENT CLASSIFICATION SYSTEM

The proposed rule includes a number of extensive changes to the IRF-PPS. We had several work groups of coders and clinicians examine the proposal in depth. Highlights of our recommendations follow; others are found in the attached comments.

A. Comorbidities

We have specific recommendations regarding the codes proposed for removal. We support moving dialysis to tier one and also recommend revisions to the IRF-PAI Items 24-47 so that preventable conditions at admission can readily be identified and added to the list of comorbidities.

B. Changes to the CMGs

We have specific comments regarding the change in the number of CMGs, drop in cognitive scores showing up as determining factors in the CMGs, length of stay and relative weights. We recommend all the data be updated as mentioned above using more current data in the face of the 75% rule before any changes are made to the CMGs. With respect to weighting the motor function items, we recommend a demonstration study be conducted before final implementation.

IV. PROPOSED FY 2006 FEDERAL PROSPECTIVE PAYMENT RATES

A. Decrease in the Standard Payment Amount

We oppose the reduction in the standard payment amount of -1.9% to account for coding. Again, because of the 75% rule, we recommend no decrease at this time pending analyses based on more current data. It appeared from the RAND report that this is a very difficult area to analyze using this early and incomplete data.

B. Market Basket

With respect to the market basket:

1. We recommend that the current update be increased to reflect the differences between the updates given in FY 2004 and 2005 and the final market basket increases.
2. We recommend an adjustment for market basket forecast errors as is utilized for other providers.
3. Otherwise, we support the rebasing and revisions leading to the creation of the RPL market basket.

C. Area Wage Adjustments

With respect to the CBSA, MSAs and wage index we recommend that the FY 2006 IRF PPS wage index be based upon FY 2002 acute hospital wage data, rather than FY 2001 acute hospital wage data.

We recommend that a one year transition using a 50% blend of the existing wage index and the new index be implemented, again based on the FY 2002 acute hospital wage data. We found several members would experience a decrease in their index of 10% or more, which would be quite disruptive.

D. Facility Level Adjustments

We support the proposed changes to the rural and LIP adjustment. However, again we urge they be updated with more current data.

With respect to the teaching adjustment we recommend adoption of the proposed teaching adjustment. However we are quite concerned that a number of long time teaching facilities, upon reviewing the Rate Setting File with provider numbers, do not see their facility identified as a teaching facility. We recommend the data be reexamined and a process be provided for providers to rectify this problem such as allowing facilities to reopen the cost report used to determine the teaching status and cap level. We also recommend the analysis be updated using more current data as noted above.

B. Outlier Threshold

On the proposal to lower the outlier threshold we recommend that the analyses pertaining to the outlier policy be conducted anew.

We also recommend that CMS consider continuing with the FY 2005 outlier threshold of $11,211. We believe that the redistribution of the estimated $113 million from the outlier pool to the base rate would mitigate some of the impact of

the other proposed standard payment rate reductions. We believe that setting the outlier threshold at an adequate level will protect the overall structure and efficiency of the IRF PPS system.

We believe that CMS should monitor this issue closely. If it is determined that access to care becomes problematic for some patient populations or that specific providers experience significant harm because of a disproportionate share of high cost outliers, modifications to the outlier percentage should be considered.

Alternatively, the work group on this issue would support the outlier provision as proposed as it will at least ensure that all of the outlier funds set-aside are paid out.

V. SITE NEUTRAL PAYMENT

CMS mentions that it is interested in looking into a site neutral payment policy. It further states that it believes it can compare clinical data across care settings through standardized electronic health resource technology. On June 16, the House Ways and Means Subcommittee on Health held a hearing looking at post acute care assessment instruments and an integrated post acute care payment system. AMRPA submitted a statement for the record which is attached (See Attachment B). There are clearly many different types of patients being served in the various post acute care sites. Patients receive varying types and amounts of rehabilitation services in home health, long term are hospitals (LTCHs), skilled nursing facilities (SNFs) as well as inpatient rehabilitation facilities (IRFs). We believe that in order to address such a broad program correctly, data should be collected on institutional inpatient rehabilitation patients initially in SNFs, LTACHS, and IRFs using the same data tool and one that is very sensitive to the change in functional status since change in function is critical to understanding care given, outcomes, and the costs of care for these patients. Only then will it be possible to compare patients, their characteristics and costs. From that point CMS could start to examine different payment structures and incentives. We have described these issues in our statement.

In its June, 2005 Report to Congress, in Chapter 5 the Medicare Payment Advisory Committee (MedPAC) examined closely the issues surrounding the various patient assessment tools and whether they are compatible in the nature, type and timing of data collected. Specifically it found that while some of the existing tools measure broad aspects of patient care, the timeframes covered, measures used to differentiate patients and the definitions of the items of care vary considerably. In its statement before the House Subcommittee it stated clearly "These differences make it very difficult, if not impossible, to compare the quality of care and patient outcomes across all settings."

Hence should CMS choose to start examining these issues, we wish to work with it closely regarding our concerns pertaining to patients receiving rehabilitation services.

CMS also mentions encouraging incremental changes and mentioned medical record tools to allow better coordinate discharge planning procedures. We wish to discuss with CMS exactly which existing medical record tools are available and how it is suggesting they might be used.

VI. CHANGES TO THE IRF PAI

While the proposed rule does not recommend changes to the IRF-PAI we recommend CMS consider several improvements since the field has now had several years of experience with it.

First, the inherent floor and ceiling effects of the tool have become more apparent now that it is in place nationally. We are concerned that those patients who are scored as a 7 (most independent) as well as those scored as a 1 (most dependent) may actually not be as homogeneous as their scores would indicate. For example, a quadriplegic may not show any change in motor or cognitive scores, yet may have had his or her quality of life increased through use of a mouth stick, head stick or sip and puff technology. To that end, we recommend that CMS consider convening a technical expert panel that can examine this issue.

Second, we are concerned as noted in our comments with the fact that the cognitive scores do not appear as frequently in driving costs in determining the new CMGs. We believe one factor is that the cognitive scores are not measuring cognitive ability and change in that ability as well as the motor functional items. We recommend that as part of the agenda for the above Technical Expert Panel that a thorough examination of the cognitive items be undertaken. These issues were touched on in the discussions of the TEP on the quality indicators project conducted by the Research Triangle Institute in North Carolina. We suggest this work be continued and developed further through a complete reexamination of the cognitive items.

Third, in its report titled "*Possible Refinements to the Construction of Function Related Groups for the Inpatient Rehabilitation Facility Prospective Payment System*" RAND notes several areas where the IRF PAI could be improved. They include:

1. Defining and refining an incontinence measure
2. Refining the function modifier for distance walked to indicate how much assistance was required for various distances and whether it is needed for neurological as opposed to cardiac or pulmonary shortcomings.

We support these recommendations.

Fourth, we recommend that the instructions for completion of Items 24, Comorbid Conditions and 47, Complications During Rehabilitation Stay, be changed to clarify that Item 24 codes should include those conditions that were present on admission when the IRF PAI is conducted. Item 47 should include those conditions that developed after that time and be completed upon discharge or during the stay. To do so would help further determine the presence of the conditions discussed under the discussion on the proposed changes to the comorbidities and tiers pertaining to preventable conditions.

We look forward to working with the Department of Health and Human Services and CMS in moving forward to refine and improve the IRF-PPS and in other related research efforts. If you have any questions about these recommendations please contact me, Ken Aitchison, Chair, PPS Task Force (201-401-1588) or Carolyn Zollar (202-223-1920).

Sincerely,

Felice Loverso, PhD
Chairman
AMRPA Board of Directors

American Medical Rehabilitation Providers Association's Comments and Recommendations on the Proposed Refinements of the Inpatient Rehabilitation Facilities Prospective Payment System (IRF PPS), CMS-1290-P, 70 F. R. 30188 et seq.
May 25, 2005

This letter is submitted on behalf of the American Medical Rehabilitation Providers Association (AMRPA). AMRPA is the national voluntary trade association which represents over 400 freestanding rehabilitation hospitals, rehabilitation units of general hospitals, and a number of outpatient rehabilitation facilities. Most, if not all, of our members are participating providers in the Medicare program. Rehabilitation facilities serve over 500,000 Medicare beneficiaries per year. Medicare represents, on average, over 60% of their revenues. Hence any change in the Medicare payment system will have dramatic implications for these providers.

We congratulate CMS for publishing the Notice of Proposed Rulemaking (NPRM) on the first refinements to the inpatient rehabilitation facilities prospective payment system (IRF-PPS), since it was implemented, effective for cost reporting periods beginning on or after January 1, 2002.

I. OVERVIEW OF PROPOSED RULE

The proposal includes the following:

- Changing the Case Mix Groups (CMGs) in terms of total number, functional descriptions, weights and length of stay.
- Initiating the use of a weighted motor score index.
- Making several changes to the comorbidity tiers including eliminating 19 conditions, moving dialysis to tier 1, adding tracheotomy cases to RIC 15 and adding V55.0 to the condition and moving 4% of cases to lower tiers.
- Moving all facilities to Core Based Statistical Areas (CBSAs) from Metropolitan Statistical Areas (MSAs) with no transition period.
- Updating the wage index based on the change to CBSAs.
- Rebasing and revising the excluded market basket to reflect the costs for long term care, psychiatric and rehabilitation hospitals (RPL).
- Increasing the facility adjustors for the low income percentage (LIP) and rural adjustment and proposing an adjustment for teaching facilities.
- Updating the outlier threshold from $11,211 in FY 2005 to $4,911 to maintain estimated outlier payments at 3% of total estimated payments.
- Decreasing the standard payment rate for a number of factors including changes in the wage index, a 1.9% decrease for coding, and a cumulative 3.38% adjustment for increases in the LIP, rural adjustment and the proposed teaching adjustment.

II. DATA

A. Implementation Using 2002 and 2003 Data in the Current Regulatory Environment

On pg. 30222, in the discussion regarding the proposed reduction in the standard payment amount for coding, CMS raises concern about the impact of that change and any potential impact on access. It also acknowledges that the current cost structures of inpatient rehabilitation facilities (IRFs) may be changing as they try to comply with implementation of the 75% rule effective for cost reports beginning on or after July 1, 2004 as published in the May 7, 2004 Federal Register, "*Changes to the Criteria for Being Classified as an Inpatient Rehabilitation Facility*". We commend CMS for recognizing these concerns and changes in the IRF environment.

We believe that the rule is having, and will continue to have, a drastic impact on the IRF field far beyond CMS's original estimates or intent. With the end of the first quarter of 2005 (the third quarter under the new 75% rule) the actual volume of Medicare patients in rehabilitation hospitals and units is down 5.8% from the same three quarters in 2003 and 2004. The drop in Medicare discharges from the second quarter of 2004 to the second quarter of 2005 is slightly over 17%. The drop for the first year of operation of the rule for Medicare beneficiaries only is 9% of discharges We think that the ultimate impact on the field using 2002 as a base year will be a reduction in Medicare payments of $506,704,806 in Medicare in FY 2006 alone and a turning away of 66,283 Medicare patients in FY 2006. See Attachment A (Analysis of Conditional Criteria) which uses an analytical model based on the text of the rule.

In so doing, the case mix of facilities will continue to change as it already has started to change, reversing the noted increases in joint replacement cases and decline in the percentage of stroke cases, among others. Eliminating care for these shorter stay, less costly patients and taking longer, stay more complex patients, along with closing beds (assuming a full substitution of cases cannot be found) will result in a change in facilities' cost structure. Hence, by October 1, 2005 when these changes are proposed to become effective they will be applied to a patient and cost environment very different and more volatile from that which was observed and upon which the research recommendations and subsequent policy recommendations were made. Another factor affecting the volatile IRF environment is the influence of various Local Coverage Decisions.

CMS notes it believes that if all facilities went initially to 100% IRF PPS payments that they would have been paid 17% over cost. We are concerned that implementing this rule into this new environment would not only eliminate all of this alleged margin but also pay for some cases below cost.

Recommendation:
We recommend that CMS delay a broad refinement to the IRF-PPS until more current data is collected and analyzed.

We recommend that CMS engage the RAND Corporation to conduct additional analyses using, preferably, Calendar 2005 data and reconvene the Technical Expert Panel (TEP) to examine these findings and then reissue the rule. Information from this period would capture, at least, the initial compliance period under the 75% rule for a large number of facilities. While these analyses are being conducted, CMS could still take several steps to update the IRF-PPS. They include:

1. Move forward with the annual update using the full market basket;
2. Rebase and revise the excluded market basket, subject to our recommendations below;
3. Move to CBSAs from MSAs, subject to the recommendations below; and
4. Continue to refine the proposal for an teaching adjustment which we support.

If CMS does not collect CY 2005 data and revise the proposed refinements, our comments on the proposed changes follow.

B. Review of Current Data

We note that throughout the discussion there are references to analyses done on 2003 data. However, several of the RAND reports made available were done on 2002 data. In addition, neither the RAND reports nor the rule shows the analysis of the weights and length of stay using the 2002 data or how these were obtained using the 2003 data. Such data tables were included in prior RAND reports, such as the "*Analyses for the Initial Implementation of Medicare's Inpatient Rehabilitation Prospective Payment System*" distributed to the TEP and made available by CMS in 2001 and 2002.

In order to make truly informed recommendations, particularly for the CMGs, weights and length of stay, we would like to have access to the 2002, and 2003 claims and cost report data. We are also concerned that several members noted serious problems with their provider numbers being incorrect in Table 3, which seriously affects their current and future geographic designation and wage index. Other members are concerned because the Rate Setting File with provider numbers does not show them as teaching facilities. Finally, we are concerned that the cost reports used may understate total IRF costs by an amount that would affect the final analyses.

Recommendation:

We recommend that CMS provide the missing and requested data to the inpatient rehabilitation field so that it can make a complete assessment of how the proposed changes were derived and their impact. Until then, we recommend that CMS not issue a final rule; or, if CMS feels compelled to issue a final rule, that it be issued in interim final form with the data in question and with comments requested.

III. PROPOSED REFINEMENTS TO THE PATIENT CLASSIFICATION SYSTEM

A. Comorbidities

1. ***Proposed Changes to Remove Codes, pg. 30194***

CMS proposes to remove approximately nineteen (19) codes from the list of tier comorbidities. CMS states that these conditions are proposed to be removed from

the tier list of comorbidities because they have no impact on cost, are indistinguishable from other codes or are unrealistically overrepresented. These are set forth on Table 1, pg. 30195.

First, we note that there may be several reasons for the findings RAND made regarding some of these codes. For example regarding code 410.91, there seems to be some confusion in the field as to when to use the acute code as opposed to the code for AMI-subsequent episode of care or the effects. Also for kwashiorkor although rare, it is the code used for protein deficiency by commonly used software packages for coding such as 3M and Meditech. It would be interesting to see if its use tracks with such software.

Recommendation:
Second, we examined Table 1 at length and convened a work group specifically on the proposed changes to the tiers and comorbidities. As a result we concur with the proposed removal of the following codes:

235.1	Neoplasm of uncertain behavior of digestive and respiratory systems, Lip, oral cavity, pharynx
933.1	Foreign body in pharynx and larynx Larynx
934.1	Foreign body in trachea, bronchus, and lung Main bronchus
799.4	Other ill-defined and unknown causes of comorbidity and mortality Cachexia[1]
250.90	Diabetes with unspecified complications, not stated as uncontrolled –
250.93	Diabetes I, with unspecified complications, uncontrolled –
410.91	AMI, NOS initial.
410.X1	Specific AMI, initial
260	Kwashiorkor
V46.1	Dependence on respirator, as long as it does not include codes V46.1, and V46.12

We also support removing the exclusion of tracheostomy cases from the pulmonary RIC 15 and Included DX V55., "attention to tracheostomy" be part of the condition.

For the other codes, we recommend as follows:

1. V49.75, 49.76 and 497.7 regarding amputation not be deleted. Also the correct code is V49.77 vs. 497.7.
2. While we agree with the removal of 261 and 262 please see the comment above regarding software packages and endnote 1. We suggest that the impact of malnutrition on increasing length of stay be studied in future RAND studies.

3. For codes 530.0, 530.3 and 530.6, our group was concerned about eliminating these codes because these patients require speech therapy intervention which

increases cost. We recommend the proposed elimination of these codes be reexamined and reconsidered.

4. For code V 49.78, V49.76 and V.497.7, our group noted that these conditions can greatly increase cost depending on the reason for the admission. For example a stroke with left side paralysis and right sided amputation will have serious mobility problems and adjustments.

5. Finally for code 356.4, we agree that it is very rare and has little effect. However the work group notes that all cases with polyneuropathy require more resources to treat. Hence before any other codes involving polyneuropathy are considered for deletion, they recommend the data be reexamined.

2. ***Proposal to Move Dialysis to Tier One pg. 30195***
Recommendation:
We support moving dialysis to Tier 1.

3. ***Proposed Change to Move Comorbidity Codes Based on Their Marginal Cost, pg. 30196***
We recommend the analyses be done again using more current data, otherwise we have no comment. Note however code 428.3 should be 478.30. The 428 series is for congestive heart failure not vocal cord paralysis, according to our clinicians and coders.

4. ***Preventable Conditions and New Conditions***
RAND also reexamined the conditions previously considered preventable, which are known to be expensive to treat and were excluded because of a concern that including them would promote poor quality care. They include such conditions as urinary tract infections, chronic skin ulcers certain, DVT codes and osteomyelitis. RAND notes that there was a unanimous opinion among the TEP members that the IRF PPS system should recognize and pay for these conditions when they are present at admission. The data seems to recognize the majority of the cases were present at admission despite serious problems with the coding instructions for Items 24 and 47.

Recommendation:
We recommend CMS revise the instructions for Items 24 and 47 to distinguish between comorbidities found at admission (when the IRF- PAI is completed) and comorbidities that develop later, and then add these codes to the tier conditions.

RAND also looked at other frequently used codes at the request of the TEP. It found a number of conditions that were not included in the current tier system and recommended that several, congestive heart failure (428.0), heart valve replacement (V43.3) and insulin dependent diabetes without mention of complications, not stated as uncontrolled (250.01) be added to the list. See Table 5.1 pg 28 "*Preliminary Analyses for Refinement of the Tier Comorbidities in the Inpatient Rehabilitation*

Facility Prospective Payment System". We note that these recommendations do not appear to be included in the proposed rule and ask CMS to explain why.

Finally our members requested an explanation as to why hemi-paresis due to an old stroke 438.2X, is not included as a comorbidity. Frequently the deficits remaining from such an event require treatment and therefore additional costs.

B. Updating the CMGs, pg. 30197

1. ***Change in the Number and Composition of CMGs***

CMS proposes to change the number of CMGs from 95 to 87, change the case weights, average lengths of stay and CMG descriptions based on rehabilitation impairment categories (RIC), age, and motor and cognitive function.

Recommendation:

Again and as noted above we are concerned that the field has not had access to the 2003 data analysis. We also recommend the analysis be conducted again using more current data and recommend the analysis using 2003 data be released to the field.

2. ***Drop of Cognitive Scores Showing as Determinants in Defining CMGs***

CMS proposes to reduce the number of CMGs. The new cut points do not include the cognitive scores as frequently as before. In the current CMGs, cognitive scores are present in 15 CMGs representing 6 RICs. In the proposed system only 5 CMGs and 2 RICs show the presence of cognitive scores as a factor in the description of the CMGs. We are concerned that they actually do affect resource utilization, LOS and caregiver burden more than the data appear to show.

Recommendation:

We recommend that CMS reexamine the orthopedic and multiple trauma CMGs in particular regarding the influence of the cognitive items on affecting cost. Second, we recommend that CMS work with rehabilitation providers to develop cognitive measures that are more sensitive to patients' status and have better predictive qualities.

3. ***Weighting the Motor Functional Items***

CMS proposes a change in the calculation of the 12 motor items that, when totaled, result in a CMG to be assigned. The proposal states that the weighting system will provide better predictability of costs. The weights range from .2 to 2.2 and serve as multipliers to the score that is assigned each patient for each item.

We are concerned that the weighting system may result in a disadvantage for patients who present with mild lower extremity dysfunction but have cognitive problems that are reflected in the current CMGs that have lower weights. Many of the upper body functional motor scores are tasks that are sequential or multi-stage and are accomplished through higher level organizational skills. Patients with cognitive impairments may display problems with tasks such as these. These

characteristics are commonly seen in patients with traumatic brain injury but are also seen in certain patients with stroke.

We are concerned that for these cognitively impaired patients, weighting the motor items will result in the following:

a. Patients with significant lower body impairment will have a higher probability of being classified in a higher paying CMG; and
b. Patients with a significant dysfunction in upper body and bladder/bowel problems will have a higher probability in being classified in a lower paying CMG. Patients with these characteristics need professional intervention that assists the patients with sequencing tasks in proper order and relatively intense levels of intervention due to the patients' inability to perform therapy tasks on their own. There is also increased likelihood that such patients need observation at night by rehabilitation nursing staff to assure that they remain safe.

Recommendation:
We recommend that the weighting system be held in abeyance at this time until it is tested on different patient groups and determined if there is any unfair CMG categorization of patients.

4. ***Average Length of Stay***
Most ALOS figures are shorter than they are in the current CMG system which we expect reflects facilities' reducing LOS and possibly managing to the mean. It is our understanding that published length of stay (LOS) are for typical cases and do not include transfer cases.

Recommendation:
a. Again, we recommend the LOS be redefined using more current data.
b. We recommend that the standard deviations be published in any final rule.

5. ***Relative Weights***
The proposed relative weights are lower overall for patients with stroke or traumatic brain injury. As noted above, we are concerned with the impact the 75% rule and LCDs is having which could severely alter resource use, and other factors affecting the weights. Such changes may affect particularly stroke, brain injury, spinal cord injury and other neurologic conditions. On another point, we were wondering why the weight for the burn CMG for Tiers 1 and 2 is the same.

Recommendation:
We recommend, again, holding these changes in abeyance until more current data is collected and analyzed.

IV. PROPOSED FY 2006 FEDERAL PROSPECTIVE PAYMENT RATES

A. Changes to Standard Payment Amount for Coding of Minus 1.9%, pg. 30220

CMS is proposing a one-time adjustment to the standard payment amount to account for coding changes observed during the first years of implementation of the IRF PPS. It is proposing to reduce the standard payment amount by 1.9% which will reduce the per case payment amount by $254. CMS states this proposal is based on RAND's analysis.

RAND found it was quite difficult to characterize how much of the change in case mix was a function in the change of the acuity of patients and how much was a function of coding due to changes in the coding instructions and more accuracy in coding. Hence it analyzed the data from two perspectives. From these analyses it constructed an upper and lower bound for both factors. It stated: "our final bounds on the causes of the increase in the CMI are:

- coding change between 1.9 percent and 5.9 percent
- real change between a 1.4-percent decline and a 2.4 percent increase."

It then recommended that CMS either "reduce weights by at least 1.9% or reduce the conversion factor by at least 1.9% less than the market basket update... Further since in 2002 many hospitals were on the PPS for only part of the year, we believe that this analysis should be repeated using more recent data in order to gauge the full impact of the PPS on case mix change."

Recommendation:
Again, because of the 75% rule, we recommend no decrease at this time pending analyses based on more current data. It appeared from the RAND report that this is a very difficult area to analyze using this early and incomplete data.

B. Proposed Adjustment to Determine the Proposed FY 2006 Standard Payment Conversion Factor, pg. 30222

1. *Revision and Rebasing of the Market Basket, pg. 30223*

CMS is proposing to create a market basket exclusively for the rehabilitation, psychiatric and long term care hospitals (RPL). In so doing it notes that the cost structure of these hospitals is more labor intensive than the other categories of excluded hospitals—children and cancer. CMS proposes to use FY 2002 as the base period for constructing the new market basket. It proposes to both revise and rebase the market basket for operational and capital costs. In so doing, CMS notes that the wages and salaries proportion of the market basket using the FY 2002 based RPL approach is higher than using the FY 1997 market basket. When wages, salaries and employee benefits are included, they represent 65.877 of costs as compared to 57.579 in the FY 1997 based market basket. Several factors are involved in this difference: the new base year, the revised LOS change and exclusion of cancer and children's hospitals.

AMRPA's predecessor organizations had been involved in various wage studies that demonstrated the considerable difference in the amount of labor in rehabilitation hospitals compared to acute care hospitals. AMRPA commends CMS for continuing to be aware of, and sensitive to, these issues in constructing this new market basket.

It also appears that CMS is using the same methodology for the capital portion of the market basket as in the final rule published on August 7, 2001.

We note in Table 9 that the increases in the FY 1997 market basket for FY 2004 was 3.6% and for 2005 was 3.8%. However, the IRFs received only 3.2% in FY 2004 and 3.1% in FY 2005 for an increase. We understand that the SNFs receive an adjustment in their update if the market basket forecast varies from the actual market basket by .25%. We recommend a similar approach be taken for the IRF update.

Recommendation:

1. We recommend that the current update be increased to reflect the differences between the updates given in FY 2004 and 2005 and the final market basket increases.
2. We recommend an adjustment for market basket forecast errors as is utilized for other providers as noted above.
3. Otherwise, we support the rebasing and revisions leading to the creation of the RPL market basket.

C. Proposed Area Wage Adjustment- Move to CBSAs from MSAs, pg.30235

In Section III, CMS proposed changes in the area wage index adjustment. By law, IRF PPS payments must reflect regional differences in wage rates. Currently, the wage adjustment is based on a wage index similar to that used to calculate DRG payments for acute hospitals. The labor portion of CMG payments are adjusted using the index to reflect the relative magnitude of wages in a hospital's region vs. average hospital wages nationally. Because the index averages to a 1.0 factor nationally, it is inherently budget neutral; i.e., increasing the wage index of one area will decrease the index in other areas.

Under current regulations, counties that are in a metropolitan area (MSA or New England County Metropolitan Area) are considered urban. They have a wage index that is based upon average acute hospital wages in the counties in their metropolitan area. Counties that are not in a metropolitan area are considered to be rural. In each state, rural counties are combined to compute an overall rural wage index for that state.

For FY 2006, CMS is proposing to change the definition of the geographical areas used for applying wage index adjustments. It would move from Metropolitan Statistical Areas (MSAs) to Core Based Statistical Areas (CBSAs), which were developed using 2000 Census data. CMS began using these new census area designations for acute hospitals in FY 2005. Under the CBSA classification system, geographic areas with at least 50,000 population are labeled as MSAs. Those with populations between 10,000 and 50,000 are called Micropolitan Statistical Areas.

For most IRFs, CMS stated that the change to CBSAs will have no impact. Under the CBSA definitions, there are 1090 counties in MSAs versus 848 under the old system. Of the 1090 counties, 737 are in the same MSA, 65 are now classified in a different MSA, and 288 were not previously in an MSA according to CMS. In cases where the MSA changed, some MSAs were consolidated into a larger MSA and some were divided into smaller geographical areas. CMS believes that the new geographical designations more accurately reflect the geographical markets in which hospitals must compete for labor.

Under the proposed changes, IRFs located in some Metropolitan Areas will be classified as rural. The transfer of Metropolitan Area IRFs to the rural category will generally increase average rural hospital wage indices, because they tend to have higher average wages than those who are currently classified as rural. This will benefit current rural hospitals. Those who lose their urban designation will generally see a decline in their wage index. However, they will qualify for the rural hospital adjustment, which is proposed to be 24.1%, that they do not receive now.

1. ***Impact on IRFs***
   Under the proposed changes, CMS estimates that 37.2 percent of IRFs will see no change in their wage index; 34.5 percent will see a lower wage index: and 28.5 percent will have a higher wage index. It estimates that 3.2 percent would see a decline of 5 percent or more.

2. ***Assessment***
   AMRPA's Wage Index Work Group considered the change from the old MSA definitions to the new CBSA labor market definitions to be reasonable. These labor market definitions have been in place for acute hospitals for DRG payments since October 2004. Furthermore, according to Table 14, 82 percent of all IRFs are units of acute hospitals.

The work group discussed whether it made sense to use acute hospital wage data for labor cost adjustments. CMS states that it believes such data is appropriate, because acute hospitals and IRFs compete in the same labor markets. At this time, wage data is not collected for IRFs in their Medicare cost reports. Hence, it is not feasible to develop an IRF-specific wage index. With only 217 freestanding rehabilitation hospitals in the country participating in the Medicare program, it would be difficult to produce wage indices for over 300 metropolitan areas that are meaningful and much different from the IPPS wage indices.

However, the work group did note a disparity between the way the acute hospital wage data is being used for acute hospitals and IRFs. Under the IPPS rules proposed for acute hospitals for FY 2006, wage index data based on FY 2002 cost reports will be used. For IRFs, CMS proposes to use FY 2001 cost report data. We believe the FY 2002 cost report data should be used for IRFs as well, because the most recent data available for computing wage indices should be applied. Furthermore, recognizing that 82 percent of all IRFs are hospital-based, it would be more consistent for them to use the same wage indices for their entire hospital.

Another difference between the change to CBSA labor market areas for acute hospitals and IRFs is the use of transition measures. Acute hospitals that lost their urban status were given a three year transition period, in which they could utilize the urban wage index of the metropolitan area in which they were previously associated. In addition, hospitals that saw a decline in their area wage index as a result of a change in their labor market area had a one year transition period, in which they received a wage index that was the average of their wage index, computed using the old labor market definitions and the wage index using the new definitions. In the proposed rule, CMS states that such transition measures are not needed for IRFs, because most did not see a large decrease in payment as a result and the increase in the rural adjustment factor from 19.14 percent to 21.4 percent compensates for that decline for many of those affected adversely.

Recommendation:

a. We recommend that the FY 2006 IRF PPS wage index be based upon FY 2002 acute hospital wage data, rather than FY 2001 acute hospital wage data.

b. We recommend that a one year transition using a 50% blend of the existing wage index and the new index be implemented, again based on the FY 2002 acute hospital wage data. We found several members would experience a decrease in their index of 10% or more.

D. Proposed Facility Level Adjustments, pg. 30241

1. Proposed Teaching Status Adjustment, p. 30241

CMS is proposing, with some reservation, recognition of the costs of providing medical education programs, specifically for the indirect teaching costs based on an analysis by RAND of the FY 2003 data. The adjustment would be calculated as 1+ the full time resident equivalent divided by the average daily census raised to the power of 1.083. The adjustment would be subject to a cap as are the IPPS hospitals and the cap established for graduate medical expenses for all hospitals. The cap would be calculated using the FTE resident number for settled cost reports for the most recent cost reporting period ending on or before November 15, 2003.

Recommendation:

Our work group on the facility adjusters recommends adoption of the proposed teaching adjustment. However we are quite concerned that a number of long time teaching facilities, upon reviewing the Rate Setting File with provider numbers, do not see their facility identified as a teaching facility. We recommend the data be reexamined and a process be provided for providers to rectify this problem. Such a process should included allowing facilities to reopen the cost report used to determine the teaching status and cap levels or check to assure that the CRP included in the original database has not been changed in the process of being settled. We also recommend the analysis be updated using more current data as noted above.

2. ***Low Income Adjustment, pg. 30245***

CMS proposed to increase the low income adjustment from ((1+DSH) ^ 0.438 to ((1+DSH) ^0.636. "DSH" represents the disproportionate share percentage as used in the final rule.

Recommendation:

We support the proposal. However, again we recommend it be rerun using calendar year 2005 data.

3. ***Rural Adjustment, pg. 30244***

CMS proposed to increase the rural adjustment from 19.1% to 24.1% to continue to recognize the higher costs of rural hospitals and units.

Recommendation:

We support the proposal, and again recommend the analysis be rerun using calendar year 2005 data.

E. Proposed Increase in the Outlier Threshold Amount, pg. 30245

Since the inception of IRF PPS, CMS has set aside an estimated three percent (3%) of total IRF payments for outlier payments in addition to the regular case payments. The statute provides that up to 5% of total payments may be set aside to account for paying for cases that have extraordinary high costs. In the 2001 IRF-PPS final rule, CMS chose to set aside 3% of total estimated payments for additional payments to these outlier cases

One of the purposes of the outlier policy is to assure access to these complex, costly patients (see August 7, 2001 Federal Register pages 41361 and 41362). CMS states that the results of financial risk, accuracy at the case level, and accuracy at the hospital level suggest that there should be a limit on the outlier percentage that is less than the statutory limit and that balances the need to compensate accurately for high-cost care while still maximizing remaining resources to improve the payment accuracy of non-outlier cases. The original threshold was $11,211. This outlier threshold has remained constant for FY 2003, 2004 and 2005 without regard to actual outlier payments.

The outlier policy has resulted in unexpended funds to providers. For example, CMS estimates that only 1.2% of the dollars allotted for outlier payments will be paid in FY 2005 (p. 30266). Hence, our work group estimated providers will be underpaid by approximately $113,000,000 in 2005 because of the current outlier threshold. Based upon the 2005 projected experience, it is possible that CMS may have retained as much as $460 million since inception of the IRF PPS, since few cases qualified as outliers, and hospitals may have not admitted potential outlier cases because of the higher threshold.

collected. Specifically it found that while some of the existing tools measure broad aspects of patient care, the timeframes covered, measures used to differentiate patients and the definitions of the items of care vary considerably. In its statement before the House Subcommittee it stated clearly "These differences make it very difficult, if not impossible, to compare the quality of care and patient outcomes across all settings."

Hence should CMS choose to start examining these issues, we wish to work with it closely regarding our concerns pertaining to patients receiving rehabilitation services.

CMS also mentions encouraging incremental changes and mentioned medical record tools to allow better coordinate discharge planning procedures. We wish to discuss with CMS exactly which existing medical record tools are available and how it is suggesting they might be used.

VI. CHANGES TO THE IRF PAI

CMS does not mention in this proposed rule the need to make amendments to the inpatient rehabilitation facility inpatient patient assessment (IRF PAI). Since the start of the IRF PPS we have been tracking issues that have arisen surrounding use of the tool. We have a separate work group evaluating these concerns at more depth. However, we mention several here. Generally its implementation, as that of the entire IRF PPS, has gone quite smoothly. We attribute that, in part, to the openness with which CMS and RAND communicated with the field directly regarding the development of the IRF-PPS. We look forward to continuing such open lines of communication.

First, the inherent floor and ceiling effects of the tool have become more apparent now that it is in place nationally. We are concerned that those patients who are scored as a 7 (most independent) as well as those scored as a 1 (most dependent) may actually not be as homogeneous as their scores would indicate. For example, a quadriplegic may not show any change in motor or cognitive scores, yet may have had his or her quality of life increased through use of a mouth stick, head stick or sip and puff technology. To that end, we recommend that CMS consider convening a technical expert panel that can examine this issue.

Second, we are concerned as noted above with the fact that the cognitive scores do not appear as frequently in driving costs in determining the new CMGs. We believe one factor is that the cognitive scores are not measuring cognitive ability and change in that ability as well as the motor functional items. We recommend that as part of the agenda for the above Technical Expert Panel that a thorough examination of the cognitive items be undertaken. These issues were touched on in the discussions of the TEP on the quality indicators project conducted by the Research Triangle Institute in North Carolina. We suggest this work be continued and developed further through a complete reexamination of the cognitive items.

Third, in its report titled "*Possible Refinements to the Construction of Function Related Groups for the Inpatient Rehabilitation Facility Prospective Payment System*" RAND notes several areas where the IRF PAI could be improved. They include:

1. Defining and refining an incontinence measure
2. Refining the function modifier for distance walked to indicate how much assistance was required for various distances and whether it is needed for neurological as opposed to cardiac or pulmonary shortcomings.

We support these recommendations.

Fourth, we recommend also as noted above that the instructions for completion of Items 24, Comorbid Conditions and 47, Complications During Rehabilitation Stay, be changed to clarify that Item 24 codes should include those conditions that were present on admission when the IRF PAI is conducted. Item 47 should include those conditions that developed after that time and be completed upon discharge or during the stay. To do so would help further determine the presence of the conditions discussed above under the discussion on the proposed changes to the comorbidities and tiers pertaining to preventable conditions.

We look forward to working with the Department of Health and Human Services and CMS in moving forward to refine and improve the IRF-PPS and in other related research efforts. If you have any questions about these recommendations please contact Felice Loverso, PhD, AMRPA Chairman (909-593-0153), Ken Aitchison, Chair, PPS Task Force (201-401-1588) or Carolyn Zollar (202-223-1920).

[1]One of the nutritionists in a freestanding rehabilitation hospital had the following observations about the removal of the nutritionally related comorbidities codes: "While I agree that these comorbidity codes are rarely used and therefore should be removed, what they represent needs to be better defined and re-coded. Codes for malnutrition do exist, but are ill-defined, rendering them useless. Hospital acquired malnutrition was first defined in 1979 and since then the incidence has increased, not decreased.

In many cases malnutrition is unavoidable and in my opinion is the main contributing factor for why acute care patients are unable to go directly home from the hospital. Unfortunately, the consequences of hospital acquired malnutrition do not present until transfer to a secondary facility. For example, a stage 1 pressure ulcer quickly evolved into a stage IV, a surgical wound. The patient did not have an opportunity to eat in acute care and after a few days of rehab is sent back to the hospital for peg placement.

What is needed is a comorbidity code that indicates a compromised nutritional status to the point of markedly interfering with the person's ability to participate in rehab. This code would be used to offset the cost of nutritional intervention as well as increase the person's covered rehab days. There are standards to determine nutritional status. They include significant weight loss from usual weight and discharge/admission albumin and pre-albumin levels. Over 80% of our non-orthopedic patients present with some degree of weight loss!"

Projected Impact of the 75% Rule

AMRPA / eRehabData®
Conditional Compliance

	Year 1 50%		Year 2 60%		Year 3 65%		Year 4 75%	
	July 2004 - June 2005 02-03 Base Year	July 2004 - June 2005 03-04 Base Year	July 2005 - June 2006 02-03 Base Year	July 2005 - June 2006 03-04 Base Year	July 2006 - June 2007 02-03 Base Year	July 2006 - June 2007 03-04 Base Year	July 2007 - June 2008 02-03 Base Year	July 2007 - June 2008 03-04 Base Year
Analysis Based On Sample Data								
Total Discharges	159,642	165,592	159,642	165,592	159,642	165,592	159,642	165,592
Medicare Discharges	110,102	112,708	110,102	112,708	110,102	112,708	110,102	112,708
Dropped Discharges	10,845	10,511	23,321	23,065	30,745	30,642	46,103	46,316
Dropped % of Total	6.79%	6.35%	14.61%	13.93%	19.26%	18.50%	28.88%	27.97%
Dropped M/C Discharges	7,319	7,088	15,876	15,677	21,357	21,222	33,103	33,239
Dropped M/C % of Total	6.65%	6.29%	14.42%	13.91%	19.40%	18.83%	30.07%	29.49%
Total Days	2,150,590	2,189,533	2,150,590	2,189,533	2,150,590	2,189,533	2,150,590	2,189,533
Medicare Days	1,407,820	1,411,751	1,407,820	1,411,751	1,407,820	1,411,751	1,407,820	1,411,751
Dropped Days	54,084	51,018	136,694	131,789	194,013	188,559	337,015	330,109
Dropped % of Total Days	2.51%	2.33%	6.36%	6.02%	9.02%	8.61%	15.67%	15.08%
Dropped M/C Days	36,310	34,499	93,773	90,943	136,622	133,412	247,371	243,828
Dropped M/C % of Total Days	2.58%	2.44%	6.66%	6.44%	9.70%	9.45%	17.57%	17.27%
Grossed Up To Entire Industry								
Gross Total Discharges	620,191	620,191	620,191	620,191	620,191	620,191	620,191	620,191
Gross M/C Discharges	459,682	459,682	459,682	459,682	459,682	459,682	459,682	459,682
Gross Dropped Discharges	42,132	39,367	90,599	86,385	119,441	114,763	179,105	173,467
Gross Dropped M/C Discharges	30,557	28,909	66,283	63,939	89,167	86,554	138,207	135,566
Gross Dropped Total Days	210,112	191,078	531,038	493,587	753,720	706,207	1,309,266	1,236,355
Gross Dropped M/C Days	151,595	140,707	391,506	370,913	570,407	544,121	1,032,789	994,458
Gross Dropped M/C Payment	$212,172,345	$208,386,597	$506,704,806	$515,596,845	$716,038,365	$736,536,444	$1,193,991,390	$1,242,645,837
Gross Dropped Total Payment	$292,543,287	$283,771,669	$692,590,086	$696,598,844	$959,147,873	$976,582,618	$1,547,315,461	$1,590,059,789
Ave Dropped M/C Payment	$6,943	$7,208	$7,645	$8,064	$8,030	$8,510	$8,639	$9,166
Ave Dropped Total LOS	4.99	4.85	5.86	5.71	6.31	6.15	7.31	7.13
Ave Dropped M/C LOS	4.96	4.87	5.91	5.80	6.40	6.29	7.47	7.34

Source: July 2002 – June 2003 eRehabData discharges
Source: July 2003 – June 2004 eRehabData discharges

American Medical Rehabilitation Providers Association

STATEMENT BEFORE THE HOUSE WAYS AND MEANS
SUBCOMMITTEE ON HEALTH
HEARING ON POST-ACUTE CARE

June 16, 2005

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WAYS AND MEANS SUBCOMMITTEE ON HEALTH HEARING ON POST-ACUTE CARE

The American Medical Rehabilitation Providers Association (AMRPA) is the leading national trade association representing over 450 freestanding rehabilitation hospitals, rehabilitation units of acute care general hospitals and numerous outpatient rehabilitation services providers. Our members serve over 450,000 patients per year, and most, if not all, of our members are Medicare providers. We appreciate the Subcommittee's focused attention on post-acute care services in Medicare. Rehabilitation hospitals and units are a crucial part of the spectrum of post-acute care providers, and we believe it is important to examine the issues surrounding this complex area of care.

An ongoing debate exists among policymakers, providers and various organizations about whether skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs) and possibly long term care hospitals (LTCHs) provide the same programs and activities with equivalent outcomes to patients needing medical rehabilitation services. Facilities should be compared both by their physical attributes, and the complete nature of the care and services they are organized to provide. Comparing facility performance solely by patient diagnoses or cost provides an extremely limited picture of the patients treated in these settings, the nature and value of the care they receive. One must look at additional patient information to truly appreciate the patients and their characteristics.

IRFs provide programs of care that utilize skilled rehabilitation services to Medicare patients at a pace, intensity, and sophistication that cannot be obtained in other health care settings. IRFs provide intense rehabilitation medicine and therapy to patients with 24-hour nursing and physician services. Patients receive a high-quality, coordinated program of care with the goal of achieving the maximum level of function possible and a rapid return to the community.

ARMPA shares the Committee's interest in examining the complicated issues surrounding assessment tools and looking at other ways to address payment across post acute providers, and we appreciate the opportunity to present our recommendations to the Committee.

75% Rule

One overarching concern facing all post-acute care rehabilitation providers is the dramatic impact implementation of the 75 Percent Rule on patient access to rehabilitative care. The 75% Rule is unquestionably having a more severe impact on patients and providers than CMS or OMB originally estimated. The Medicare program originally estimated that implementation of the 75% Rule would reduce payments to IRFs by $10 million in FY 2005 and $30 million in FY 2006. However, the President's FY 2006 Budget revised these estimates to show a savings of $50 million in FY 2005 and $70 million in FY 2006. AMRPA's own data suggest that Medicare is likely to save $165 million dollars in the first year alone. Clearly, CMS did not anticipate such a dramatic decline in patient services as a result of implementing this regulation.

Most alarming is the impact the rule is having on patients' access to treatment. Clear evidence now exists that IRF discharges have started to decline, and this change is orders of

magnitude greater than CMS estimated. ERehabData®, AMRPA's data service, estimates that in the first year alone, over 39,000 patients will be refused admission to inpatient rehabilitation facilities in order for hospitals to maintain compliance with the new 75% Rule. For the first three quarters under the new 75% Rule, volume is down 5.8% from the comparable three quarters in 2003 and 2004, meaning that approximately 20,000 Medicare patients have been denied admission since July 1, 2004. By the fourth year of the 75% Rule, IRFs will be forced to turn away one out of every three patients in order to remain compliant. As noted in the GAO Report entitled "More Specific Criteria Needed to Classify Inpatient Rehabilitation Facilities," only 6 percent of IRFs will be able to meet the 75 percent threshold required at full implementation of the rule at the end of the transition period. Without any direction from Congress, the 75% Rule is eliminating intensive inpatient rehabilitation as a treatment option for a significant number of Medicare beneficiaries.

At the core of the 75% Rule seems to be a mistaken reliance on the assumption that one site of care can be substituted for another with no impact on quality or outcomes. In particular, CMS, in promulgating changes to classification criteria for IRFs, assumed that SNF and other post-acute care settings can be substituted for IRFs if patients are denied care due to the exclusion criterion in the 75% Rule, and that this is clinically acceptable and economically desirable. AMRPA strongly disagrees with this premise. IRFs provide a very unique, specialized, intensive form of rehabilitative care that cannot be duplicated in other Medicare settings. Given the enormous impact the 75 Percent Rule has had on inpatient rehabilitative care, AMRPA urges the Ways and Means Committee to consider legislation that would hold the 50% threshold for compliance for two additional years. Moreover, to facilitate collaborative relationships with federal policymakers, AMRPA urges consideration of a federal advisory council on medical rehabilitation that would work with CMS to properly characterize IRFs and separately establish workable guidelines to distinguish appropriate patient selection criteria.

Current Financing for Post-Acute Care Services

Current Medicare program post-acute care policy is focused on providing care based on types of providers, with the key post-acute care institutional providers being LTCHs, IRFs and SNFs. While all of these sites provide post-acute care to Medicare beneficiaries, each site of care currently utilizes its own prospective payment system. The SNF PPS began in 1998 and is based on a per diem payment unit. SNFs use a patient classification system called resource utilization groups (RUGs), of which there are 44 groups. On May 19, CMS issued a proposed rule to change the RUGs and increase the number to 53. In contrast, the LTCH PPS is based on a per discharge payment unit and uses LTCH DRGs, of which there are currently 550. The LTCH PPS is being phased in over 5 years. Finally, the IRF PPS was initiated in January 2002 and is also based on a per discharge payment unit. There are 21 Rehabilitation Impairment Categories (RICs) and 95 case mix groups (CMGs) with four payment tiers, for a total of 380 possible CMGs and separate HIPPS codes. Each system is based on research reflective of the costs of care in a base year used to calculate the payment rates.

CMS, MedPAC and others have expressed concern that the post-acute care payment systems provide incentives for engaging in behavior solely to enhance reimbursement, without regard to quality or appropriateness of care, patient outcomes or cost. Policymakers must realize that looking at payments in the context of diagnoses only, without looking at other factors, can be

quite startling but does not reveal much about patient differences and reasons why a particular setting (1) best suits the need of that patient and/or (2) contains the resources necessary to obtain the optimum patient outcome. For example, payment for a stroke case may vary from $31,496.00 in an LTCH to $8,905 in a SNF according to a MedPAC report in June 2004 examining the most severe stroke cases (Chapter 5, June 2004 report on LTCHs). However, since those figures are for the most severely ill types of patients in that diagnosis, the numbers cited do not reflect the average payment, which is considerably lower. For example, the average Medicare payment for a stroke in an IRF in 2003 was $16,769.00 according to AMRPA's eRehabData®.

While federal policymakers understandably look closely at payment differentials, these payments encompass costs that are larger than the individual patient being treated. All of the payment systems discussed are based on historical costs that reflect not only patient care but also the setting-specific requirements and different Medicare Conditions of Participation each type of entity must meet. These requirements vary considerably by setting in the length, depth, scope and cost of compliance. Each system also relies on some patient's diagnosis information and varying amounts of functional information.

AMRPA has closely analyzed cost reports for SNFs and IRFs, examining both routine costs and ancillary costs in order to determine any differences between the two settings and whether such differences are representative of varying levels of services delivered. When the SNF PPS and IRF PPS were under development in 1998, AMRPA analyzed the available costs reports for 1996 to see what the impact of a prospective payment system would be on SNFs. AMRPA found that there were higher costs in hospital-based SNFs than freestanding SNFs, a finding later reaffirmed by MedPAC reports. These findings suggested that a different type of patient was being treated with more complex needs in the hospital-based SNF setting. At the time of the analysis, the average length-of-stay (ALOS) for the hospital-based SNFs was 16.56 days, in contrast to 45.03 days in the freestanding SNFs.

AMRPA also examined routine and ancillary cost differences between IRFs and SNFs. It was clear that both the routine costs and ancillary costs were higher in the IRF setting, reflecting the greater intensity of care. IRFs had higher ancillary costs per day ($274 per day for rehab units; $134.74 for SNF hospital based units; $268 for rehab hospitals; and $118.96 for freestanding SNFs), as were specific therapy charges. However, we believe that ancillary costs have decreased in response to the SNF cuts and therapy cuts in the Balanced Budget Act of 1997 and the implementation of the SNF PPS. Such a decrease would reflect a reduction in the amount of therapy delivered and the intensity of care. AMRPA is currently working on updating this information using 2002 costs reports.

The cost differential between SNFs and IRFs is significant, but the cost variation represents differences in prospective payment systems and the greater intensity of care provided in the inpatient rehabilitation setting. Thus, the faulty belief that care is equivalent among post-acute care settings is also leading CMS to argue that Medicare is paying too much for some patient care provided in IRFs. In its September 9, 2003 proposed IRF rule, CMS assumed that the average payment for an IRF was $12,525 and that by substituting care at a payment of $7,000 per case it would "save" approximately $5,525 per case. It is clear now that the cases being denied access to IRF care due to the 75% Rule are primarily lower extremity joint replacement cases

whose payments on average in 2004, based on eRehabData®, were approximately $9,151. Hence the actual difference in payments is only $2,151 per case. Additionally, these numbers may also be misleading because of differences in lengths of stay. If the average Medicare SNF stay for similar cases is 31 in 2001 and 33 days in 2003 according to MedPAC, at an average daily rate of approximately $400, then the payment is closer to $12,000 thereby further reducing Medicare's alleged savings. We would be pleased to provide the Committee with the AMRPA analysis.

Services Provided in IRFs Compared to Other Post-Acute Care Settings

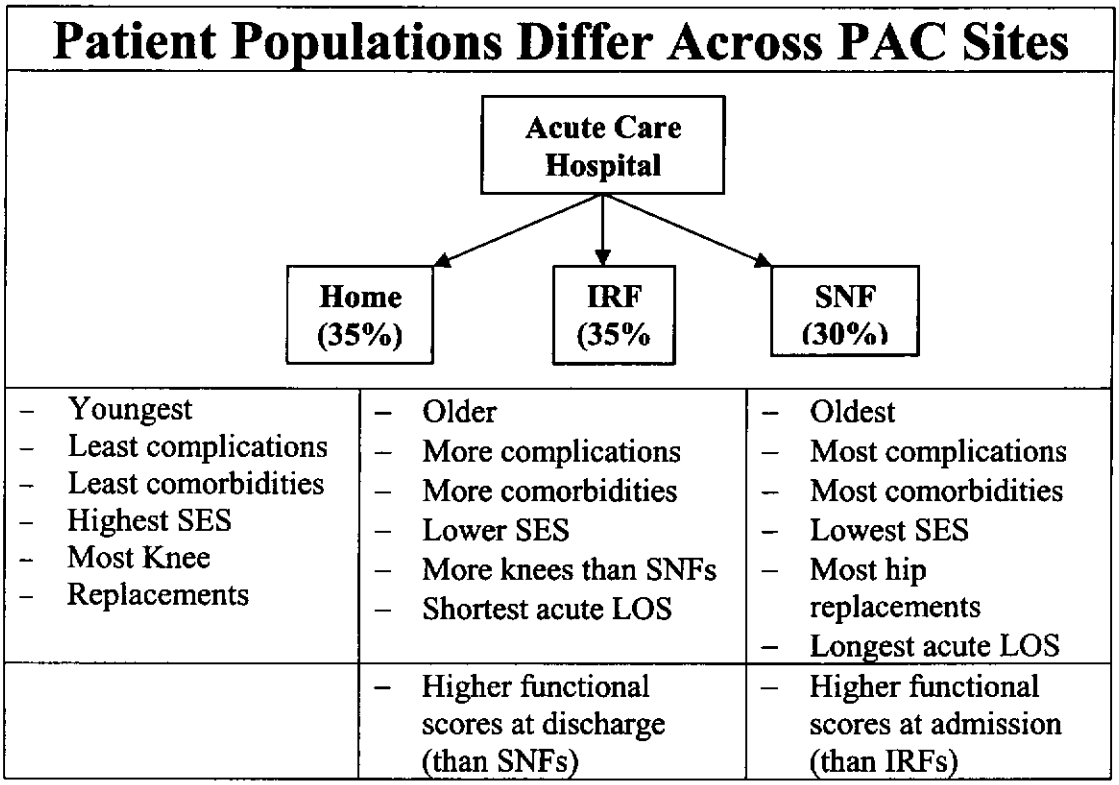
One frequent discussion in comparing settings is whether a nursing home or skilled nursing facility can substitute for IRF care and provide equivalent services and outcomes. Practitioners find that in general, nursing homes and skilled facilities do not have all the characteristics of an IRF. Facilities may share some characteristics with IRFs, but this varies widely geographically. IRFs are subject to a number of standards that no other post-acute care setting must meet, including: (1) close medical supervision by a physician with specialized training in rehabilitation; (2) patients must undergo at least 3 hours a day of physical and/or occupational therapy; and (3) a multidisciplinary approach to delivery of the rehabilitation program. (Please find attached a chart delineating a comparative analysis of SNF and IRF coverage criteria). There are no comparable specific standards for other facilities relating to rehabilitation services (such as the 'three hour rule" for IRFs), and, therefore, each nursing home or SNF must be evaluated individually.

A good illustration of the difference in services provided in these rehabilitation settings can be seen in the Spring 2005 MedPAC analysis examining single hip and knee joint replacements in IRFs and SNFs. MedPAC commissioned the RAND Corporation to study outcomes across settings for hip and knee replacement cases in response to changes to the 75% Rule that would force fewer hip or knee replacement patients to be treated in IRFs each year. MedPAC staff conducted two studies and presented the results at the April 2005 meeting. The first study involved a physician panel of six (6) orthopedic surgeons and five (5) specialists in physical medicine and rehabilitation. The physician panel noted that close to 50-80% of such patients go home with home health care or outpatient services, and therefore not to institutional settings. The panel said that patients who could not go home should have the following characteristics for referral to a SNF or IRF:

- Be limited in weight bearing or unable to walk 100 feet;
- Be obese or have comorbidities;
- Have an impairment of one or more joints (not replaced);
- Have diminished pre-surgery functioning; or
- Have architectural barriers or no informal caregiver at home.

Panelists also said that patients who need extra medical attention should go to IRFs, while patients who need convalescent care or cannot tolerate 3 hours per day of therapy should go to SNFs. In some communities, surgeons refer based on the qualifications of specific facilities that are available, such as how the facilities are staffed, whether they follow rehabilitation protocols or are convenient for the surgeon to follow-up.

Another point MedPAC has clearly established is that the types of patients treated in each setting are considerably different. MedPAC recently examined the types of patients in SNFs, IRFs and home health agencies (HHAs) receiving care for single joint replacements. Specifically, it found that:



* MedPAC Staff Handout, April 2005 Meeting

RAND presented a number of conclusions about the differences in cost and care among settings. Generally, RAND found that the functional level of patients in IRFs was lower at admission than in SNFs, but patients ultimately had greater functional gains, suggesting that the greater intensity of therapy in IRFs improves functional status. In addition, after controlling for a number of variables, RAND found that SNF and IRF patients were more likely to be institutionalized compared to patients sent home. However, 2.5 times more patients in SNFs were institutionalized or died (0.46%) than those in IRFs (0.18%). Further, as expected, SNFs and IRFs were paid more than patients discharged home. RAND found that SNFs cost $3578 and IRFs cost $8,023 for total post-acute payments as opposed to home care. Note, however, that these figures are misleading and understated for home health costs and SNF costs because they do not include any Part B outpatient services provided.

AMRPA is particularly concerned that patients referred to LTCHs and IRFs are being pressured by Medicare into staying in acute care longer or treated in SNFs. This view has become much more prevalent as CMS issues regulations that are detrimental to certain sites of care, such as CMS's FY 2005 LTCH rate year update, the IPPS FY 2005 proposed rule proposal pertaining to hospitals within hospitals, and the various proposed and final rules pertaining to the 75% Rule for IRFs. Many post-acute care LTCH and IRF providers are left with the impression that a federal bias in defining LTCHs and IRFs more narrowly is designed to: (1) close many of these facilities; and (2) force patients to be treated in skilled nursing facilities (SNFs). Many post-acute care providers and

INPATIENT REHABILITATION FACILITIES PROVIDE A REHABILITATION SETTING DISTINGUISHABLE FROM SKILLED NURSING FACILITIES

COVERAGE CRITERIA

CMS assumes that post-acute rehabilitation care settings are readily interchangeable. In doing so, CMS ignores the enormous difference between the two care settings and the improved outcomes that occur at IRFs.

REQUIREMENTS	INPATIENT REHABILITATION FACILITIES	SKILLED NURSING FACILITIES
Medical Supervision	IRFs are required to provide close medical supervision by a physician with specialized training or experience in rehabilitation.	A SNF patient's care would usually require only the general supervision of a physician, rather than the clos supervision which rehabilitation patients need
Availability of Rehabilitation Nursing	IRFs are required to supply 24-hour rehabilitation nursing. This degree of availability represents a higher level of care than is normally found in a SNF.	While a SNF patient may require nursing care, specialized rehabilitation nursing is generally not as readily available in such a facility.
Intensity of Care	IRFs must offer a relatively intense level of rehabilitation services. The general threshold for establishing the need for inpatient hospital rehabilitation is that the patient must require and receive at least 3 hours a day of physical and/or occupational therapy.	SNFs are only required to offer services on a "daily basis," with no requirement as to amount of patient ca
Multidisciplinary Team Approach to Care	IRFs must use a multidisciplinary team approach to delivery of the rehabilitation program. At a minimum, a team must include a physician, rehabilitation nurse, commonly registered nurse, social worker and/or psychologist, and other therapists involved in the patient's care.	No such multidisciplinary approach is required at a SN hospital.
Coordinated Program of Care	IRF patient records must reflect evidence of a coordinated program of care, i.e. documentation that periodic team conferences were held with a regularity of at least every two weeks to assess the individual's progress and consider the rehabilitation goals of the patient.	SNFs must only maintain a complete and timely clinic record of the patient which includes diagnosis, medica history, physician's orders, and progress notes.
Significant practical improvement	Hospitalization after the initial assessment is covered only in those cases where the initial assessment results in a conclusion by the rehabilitation team that a significant practical improvement can be expected in a reasonable period of time.	Services must be reasonable and necessary for the treatment, be consistent with the nature and severity o the illness or injury, and must be reasonable in terms c duration and quantity.
Realistic goals	The most realistic rehabilitation goal for most Medicare beneficiaries is self-care or independence in the activities of daily living; i.e., self-sufficiency in bathing, ambulation, eating, dressing, homemaking, etc., or sufficient improvement to allow a patient to live at home with family assistance rather than in an institution. Thus, the aim of the treatment is achieving the maximum level of function possible.	Rehabilitation services must be "reasonable and necessary" to the ailment being treated. The SNF manual makes no reference to rehabilitation goals.

Sources: IRF – Medicare Benefit Policy Manual §110.4 (Rehabilitation Hospital Screen Criteria) SNF – Skilled Nursing Facility Manual, Pub. 12, §214 (Covered Level of Care)

July 18, 2005

Honorable Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 443-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

RE: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for FY 2006; Proposed Rule CMS-1290-P

Dear Dr. McClellan:

On behalf of the Providence Health System, I want to thank you for the opportunity to provide our comments on the changes proposed by CMS to the Medicare Inpatient Rehabilitation Facility Prospective Payment System (IRF-PPS) in its Notice of Proposed Rule Making on May 25, 2005. The Providence Health System is a faith-based, non-profit health system that operates nine Inpatient Rehabilitation Facilities (IRFs) in Washington State, Oregon, California and Alaska, along with acute care hospitals, freestanding long term care facilities, physician groups, home health agencies, assisted living, senior housing, PACE programs, and a health plan. In 2005 the Providence Health System served 181,853 acute care admissions. Over one-third of our system's gross revenue is charged to the Medicare program.

Providence is pleased to provide its comments and recommendations to CMS on the following issues contained in the proposed rule:

- Reduction in the standard payment amount by 1.9 percent;
- Significant refinements to the patient classification system;
- Implementation of a teaching status adjustment to payments for services provided in IRFs that are, or are part of, teaching hospitals;
- Decrease in the outlier threshold amount from $11,211 to $4,911 in order to maintain total estimated outlier payments at three percent of total payments; and,
- Establishment of an Alaska facility-level adjustment to account for higher non-labor costs in that state

GENERAL OBSERVATIONS

However, before offering its comments on these specific elements of the proposal Providence would first like to address the challenge in analyzing the *cumulative* effects of

elements of the policy – has been an early adopter of the new criteria under the restructured 75 percent rule. As an example, one of Providence's nationally recognized stroke centers calculated its average acute care case mix for patients who were subsequently transferred to its acute inpatient rehabilitation distinct part unit. When compared to its 2002 score, the 1999 case mix score increased from 1.6240 to 2.109 – a 29.9% increase. Therefore, we are concerned that an across-the-board reduction in the standard payment amount effectively punishes those IRFs that have been largely in compliance with the 75 percent rule. Additionally, we believe the 1.9 percent reduction is unnecessary because, under the PPS system, the relative weights reflect the cost differentials of different types of conditions and as such will be self-correcting as enforcement of the 75 Percent Rule proceeds.

Recommendation: We urge CMS to forego any reduction in the standard payment amount. Instead CMS should allow both the PPS and enforcement of the 75 Percent Rule to work as a means of further improving the accuracy of coding and admissions to reflect the resource needs for specific conditions. Then and only then should adjustments under the authority of Section 1886(j)(2)(C)(ii) be considered.

"PROPOSED REFINEMENTS TO THE PATIENT CLASSIFICATION SYSTEM"

Providence has historically and consistently supported efforts to improve the accuracy of patient classification systems in a manner that allows for better explanation of variation in resource use among patient groups. However, because these changes are typically made in a budget-neutral fashion they must be approached with caution so as not to present a barrier to beneficiaries needing access. Provider experience and expertise in coding needs to be well-established so thoughtful and complete analysis can be conducted. Additionally, changes in treatment patterns must have already been incorporated into care routines in order to permit a more stable and predictable linkage between cost and case mix.

As Providence reviewed the RAND work product and the proposals by CMS to refine the patient classification system there are early indications that changes will eventually need to be made that will represent improvements over the current system. However, as noted above the system is still evolving and its initial effects were still being observed in 2002. Furthermore, some of the changes in classification instructions had only just been introduced in January of 2002. Therefore it is not surprising that some of the effects of the proposed rule are simply best estimates – ***to the extent they can be fully comprehended at all.*** Providence is also concerned that these changes potentially impact the integrity of the FIM scoring system. However, taking all the proposed refinements into account many of the changes in the Proposed FY06 Payment Rate (Table 12) are significant. For example, the Tier One payment rate for CMG 0101 is increased by 57 percent over FY2005 while the Tier One rate for CMG 1101 decreases by 2.9 percent. The FY05-06 payment rate reductions for patients without co-morbidities are even more

FACILITY-LEVEL ADJUSTMENT FOR ALASKA

In the August 7, 2001 Final Rule implementing the IRF PPS, CMS noted that as a result of too few claims to analyze, the IRF PPS would not include a cost-of-living adjustment for IRFs located in Alaska and Hawaii. While we understand CMS' concern about implementing an adjustment based on a small sample of claims and caution CMS in doing so generally (see above discussion on the teaching facility adjustment), there is precedent in other Medicare payment systems (IPPS, Inpatient Psychiatric PPS) to provide an adjustment to offset the documented higher non-labor costs in Alaska.

Recommendation: Given that CMS has recognized that there is a significant differential in non-labor costs for facilities located in Alaska, we urge CMS to revisit claims from FY 2002 and FY 2003 to assess that differential for IRFs located in that state and implement an Alaska-specific cost-of-living adjustment.

CONCLUSION

Notwithstanding the comments noted above, Providence appreciates CMS' efforts to improve the accuracy of payments to reflect changes in the needs of patients. In general, we urge CMS to move with caution in adding adjustments to the IRF-PPS – particularly when they are budget-neutral and therefore will negatively affect those facilities not receiving the adjustments – until more data can be gathered and analyzed. Thank you again for the opportunity to comment on these proposed changes. If you have any questions, please contact Chuck Hawley, Vice President of Government Affairs, at (206) 464-4237 or via e-mail at chuck.hawley@providence.org.

Sincerely,

John Koster MD

John Koster, M.D.
President/CEO
Providence Health System

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RURAL HOSPITAL COALITION

RECEIVED - CMS
2005 JUL 18 A 11: 14

July 18, 2005

Via Hand

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201
Attn: CMS-1290-P

Re: Comments On *Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for FY 2006, Proposed Rule*, 70 Fed. Reg. 30188 (May 25, 2005), CMS-1290-P

Dear Sir or Madame:

The Rural Hospital Coalition appreciates the opportunity to comment on the proposed rule entitled *Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for FY 2006*, 70 Fed. Reg. 30188 (May 25, 2005), CMS-1290-P. The Rural Hospital Coalition comprises approximately 15 percent of America's rural hospitals, including those owned or operated by Community Health Systems and LifePoint Hospitals. The Rural Hospital Coalition and its members are committed to providing quality inpatient medical and surgical services, outpatient treatment, and skilled nursing care to patients close to their homes.

The Rural Hospital Coalition supports your efforts to assure that care in inpatient rehabilitation facilities ("IRF") is of the highest quality. We support CMS' use of the latest data to ensure that Medicare is paying accurately for services provided in rural areas.

Proposed Adjustment for Rural Location; Section III.4

The Rural Hospital Coalition fully supports CMS' proposal to increase the rural adjustment to the Federal prospective payment amount for Inpatient Rehabilitation Facilities located in rural areas from 19.14 percent to 24.1 percent. See 70 Fed. Reg. at 30244. This increase translates into a 3.4 percent increase in payments to those rural facilities.

We agree that rural rehabilitation facilities have 24.1 percent higher costs of caring for Medicare patients than do urban rehabilitation facilities. Increasing the rural add-on payment to 24.1 percent will ensure that Medicare beneficiaries have access to intensive inpatient rehabilitation services when they are needed.

Conclusion

The Rural Hospital Coalition appreciates the opportunity to provide comments on the Proposed Rule and looks forward to working with CMS to ensure that quality health care continues to be delivered in rural communities. If you would like to discuss these issues further, please do not hesitate to contact our outside counsel, Nancy Taylor at (202) 331-3133. Thank you in advance for your consideration of these comments.

Sincerely,

Wayne T. Smith
Chairman, President & CEO
Community Health Systems, Inc.

Kenneth Donahey
Chairman & CEO
LifePoint Hospitals, Inc.

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JUL 18 2005

July 11, 2005

RehabCare
delivering the post-acute continuum

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Dr. McClellan:

RehabCare Group Inc. ("RehabCare") is a publicly owned company that manages inpatient rehabilitation units in hospitals across the country. RehabCare appreciates the opportunity to provide comments and recommend options in response to the Inpatient Rehabilitation Facility Prospective Payment System for FY 2006; Proposed Rule, as published in the Federal Register on May 25, 2005 on pages 30188 through 30327. We respectfully submit these comments.

I. Proposed Refinements to the Patient Classification System

Proposed Changes to the Existing List of Tier Comorbidities

We disagree with the proposal to remove certain codes from the tier list. In particular, 261 (nutritional marasmus), 262 (other severe protein calorie deficiency), and 260 Kwashiorkor are being removed due to excessive utilization, despite their positive correlation to cost. Since these conditions are positively related to cost, the removal of these codes will negatively and unfairly impact reimbursement for patients with these conditions. We believe it is more appropriate to resolve this problem through increased review of patients coded in this manner for medical appropriateness. We also disagree with the proposal to eliminate 410.X1 (specific AMI, initial) from the tier list. Although AMI, NOS, initial may not be positively related to treatment cost, it does not appear that it has been shown that other specific AMI are not positively related to cost. We believe further analysis is warranted to ensure that this is true.

Proposed Changes to the CMGs

We agree with the objective of improving the correlation between reimbursement and the cost of delivering care, as well as maintaining budget neutrality. However, we are concerned that the weights as proposed will not ultimately attain these objectives. Our analysis calls into question the budget neutrality of the adjustments. We examined over 11,000 recent patient records from 113 facilities, and applied the proposed rules to their admission. If the adjustments were budget neutral, we would expect no change in case mix over such a large sample of patients. Our analysis predicts a reduction in case mix

index (CMI) of greater than 2.5%. We cannot be sure of the cause of this difference, but we suggest that it is likely due to the implementation of the revised 75/25 percent rule, which was not in effect in 2002. Because the 2002 data does not reflect the implementation of revised 75/25 percent rule, it does not reflect the current or future patient mix. We believe it would be most appropriate to postpone restructuring the CMG's until the revised 75/25 percent rule is fully implemented. At a minimum, we believe it would be appropriate to examine the estimated CMI impact based on data from facilities that have already started phase-in of revised 75/25 percent rule. We would prefer that the weightings be adjusted to reflect a constant CMI. However, if the currently proposed weightings are adopted, we believe it would be appropriate to increase the base rate by a factor to ensure the reimbursement on the current patient mix is not further negatively impacted due to an unintended decrease in the CMI.

We are also concerned that the new weightings run counter to the goals of the revised 75/25 percent rule. Based on our analysis, it is apparent that the CMG's for the highest functioning patients in each RIC are receiving the greatest increases in reimbursement. Alternatively, the CMG's for the lowest functioning patients in each RIC are receiving the greatest decrease in reimbursement. Consequently, facilities that care for the greatest acuity patients are most negatively impacted by the new case weights. At a time when the revised 75/25 percent rule mandates an increase in the acuity of the patient mix and restricts admissions, we are concerned that drastically reducing reimbursement for the admissions that will remain further unnecessarily threatens access to care.

II. Proposed FY 2006 Federal Prospective Payment Rates

Proposed Reduction of the Standard Payment Amount to Account for Coding Changes

We are concerned about the 1.9% downward adjustment that CMS has proposed to eliminate the impact of coding changes. In particular, we are concerned that RAND's methodology to estimate the lower bound of the impact may have neglected to recognize certain changes that occurred between 1999 and 2003. One of the key assumptions in their analysis is that changes in patient coding and diagnoses in rehab facilities should be similarly reflected in the patients' preceding acute med/surg stay. We don't necessarily disagree with this assumption; however it does not consider potential changes in the med/surg length of stay preceding admission to acute rehab. We believe that a decline in med/surg length of stay preceding admission to acute rehab could have affected caregivers' abilities to fully diagnose patients prior to their acute rehab stay. We believe these patients may now be more fully diagnosed in the acute rehab setting.

CMS has also requested comments on the effect of the proposed range of reduction on access to IRF care. Any downward adjustment to reimbursement has the potential to negatively impact access to patient care. Obviously, the proposed 1.9% reduction in reimbursement is less threatening than a 5.8% reduction. However, this reduction must be viewed in context of the other proposed rules and the continued implementation of the

revised 75/25 percent rule. We anticipate a number of facilities will be severely impacted by the current proposed rules, raising serious concerns about their ability to continue operations. This reduction comes at a time when many inpatient rehabilitation facilities are struggling to comply with the revised 75/25 percent rule. As facilities are forced to restrict access due to the revised 75/25 percent rule, they become less efficient. As labor costs, administrative costs, and occupancy costs are spread across fewer patients, it is logical to expect that costs per discharge will increase significantly. We are concerned that reductions in reimbursement will further threaten the viability of acute rehabilitation in these facilities.

Proposed Revision of the IRF PPS Geographic Classification

We agree in principal with the adoption of the new CBSA designations. However, we do have several concerns about the short term impact of their implementation. We are especially concerned about the drastic decline in reimbursement at facilities that are going from a rural to urban designation. The proposed rule states that 91% of rural facilities that would be designated as urban under the proposed rules will experience an increase in the wage index and that 74% of these facilities will receive an increase of five percent to ten percent. We believe this means that virtually all facilities changing from rural to urban status will be seriously impacted, with reimbursement declining at least 10% in the best case scenario, and declining greater than 20% in the worst case scenario. We believe that this seriously threatens access to care in these areas, areas that up until this point have been considered rural. We believe it is appropriate to allow a transition of no shorter than three years to the new status. This would allow the affected facilities an opportunity to make operational changes and evaluate the long-term viability of the program. We believe the loss of rural status, in conjunction with the multitude of other changes at this time, may greatly reduce access to care in these areas.

We are also concerned about large swings in area wage index in some areas. We believe it would be reasonable to implement a transition period for areas that are highly impacted by this change.

Proposed Teaching Status Adjustment

We strongly disagree with the proposed teaching status adjustment. We share CMS's concern that the correlation between costs and a facility's teaching status may be a one-year aberration. Furthermore, we are concerned that increased costs for treating patients in teaching institutions do not reflect increased patient acuity, but instead reflect inefficiencies inherent in many teaching facilities. The CMG's are designed to capture patient acuity. Proper coding should ensure that teaching facilities receive appropriate reimbursement for any increase in patient acuity they have over the average. Increasing reimbursement for inefficiencies unjustly rewards the offending facility at the expense of other, more efficient facilities. Additionally, teaching facilities are not likely to cease their mission, or limit access to care, if they do not receive this additional reimbursement.

We are also concerned that the teaching status adjustment as proposed is inequitable. In particular, capping an IRF's FTE resident count based on the cost report ending on or before November 15, 2003 is arbitrary. Furthermore, it is not clear that all facilities would have carefully reflected an FTE count specific to rehab, as it did not impact reimbursement.

We thank you for the opportunity to comment on the proposed IRF PPS rule and welcome the opportunity to provide any further input that you wish on inpatient rehabilitation services. Should you have any questions, please contact me at (314) 659-2100.

Very Truly Yours,

Patricia M. Henry

Patricia M. Henry
Executive Vice President
RehabCare Group, Inc.

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JUL 18 2005

AAMC

VIA ELECTRONIC SUBMISSION AND HAND DELIVERY

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Jordan J. Cohen, M.D.
President

July 18, 2005

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
Room 445-G
200 Independence Ave, SW
Washington, DC 20201

Attention: 1290-P

Dear Administrator McClellan:

The Association of American Medical Colleges (AAMC) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled *"Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for FY 2006."* 70 Fed. Reg. 30188 (May 25, 2005). The AAMC represents approximately 400 major teaching hospitals and health systems; all 125 accredited U.S. allopathic medical schools; 94 professional and academic societies; and the nation's medical students and residents.

This year's proposed rule would make significant changes to the inpatient rehabilitation facility (IRF) prospective payment system (PPS). I write to convey the Association's strong support of the proposals to a) include a teaching hospital adjustment, and b) increase the low-income patient adjustment.

At the outset, I would like to commend the CMS staff for the clarity and completeness of the discussion of the IRF PPS and the proposed changes. Such a well-written document makes it much easier to understand the changes proposed, which allows us to provide more meaningful comments.

THE PROPOSED IRF PPS TEACHING ADJUSTMENT

CMS is proposing a payment adjustment for teaching inpatient rehabilitation facilities. (70 Fed. Reg. at 30241-244). We believe such an adjustment is well-justified and long overdue. Including it in the final rule will ensure payment equity across all providers, which will go a long way to maintaining a stable and fair Medicare inpatient rehabilitation prospective facility payment system.

Over half of the AAMC's Council of Teaching Hospitals and Health Systems (COTH) acute non-Federal members have rehabilitation units and a major rehabilitation teaching hospital also is a COTH member. These facilities play a special role in the provision of rehabilitation services. Often they possess the sophistication and infrastructure to manage the rehabilitation phase of treatment for patients with the most complex diseases and conditions. These facilities also differ from other providers because they are sites for clinical education for all types of health professional students and residents, and offer an environment in which clinical research can flourish.

I. THE IRF PPS MUST INCLUDE A TEACHING ADJUSTMENT

Since the beginning of the IRF PPS there has been a disparity in the payment equity for teaching facilities. This was demonstrated in the financial impact table accompanying the initial IRF PPS final rule. The analyses conducted by the RAND Corporation (RAND) using 2003 data show that this inequity is continuing. As RAND demonstrated, teaching rehabilitation facilities have higher costs than their non-teaching counterparts and these higher costs are associated with their teaching status. Consequently, without an adjustment, they will continue to fare worse under a national average payment system.

RAND's results are not surprising -- clinical operations are inherently more costly when teaching and training are involved and facilities with larger teaching programs generally treat more costly patient populations. Such a finding has been borne out in both the inpatient acute and psychiatric prospective payment systems, both of which include a teaching adjustment.

In the proposed rule preamble discussion, CMS expresses some concern about including a teaching adjustment, noting that RAND's analyses involved only a single year of data (2003) and that RAND did not find a statistically significant teaching affect when it did its original analyses in 2000. We believe such concerns are unfounded and do not warrant overriding RAND's statistically valid findings.

RAND's original analyses were based on pre-PPS (1999) data from only a sample of hospitals, of which major teaching hospitals were under-represented. By contrast, their current analyses were based on post-PPS (2003) data, representing the universe of Medicare IRF cases. As CMS noted "this larger file enables RAND to obtain greater precision in the analysis and ensures a more balanced and complete picture of patients under the IRF PPS" (70 Fed. Reg. at 30197). In addition, RAND utilized an expert panel that "reviewed RAND's methodologies and advised RAND on many technical issues" (70 Fed. Reg. at 30196).

CMS also expressed a concern about implementing an adjustment at the current time because other changes that might be implemented could affect future data outcomes. We strongly believe that theoretical, non-specific, concerns about the future should not override current analytically-sound analyses.[1] As with all of Medicare's payment

[1] We also understand that there might be some concern about the impact of the full implementation of the 75 percent rule on the rehabilitation PPS and any payment adjustments. Once again, we believe any such

systems, policies and decisions are, and must be, made based on the best data currently available. If, in the future, data analyses show different results, CMS has the authority to make modifications to the system, including the teaching adjustment. Unlike the inpatient acute PPS, in which changes to the indirect medical education (IME) adjustment requires legislative action, CMS has ample opportunity to modify the IRF teaching adjustment through the regulatory process if that is deemed appropriate at a later date.

In sum, RAND's analyses demonstrate that teaching IRFs were underpaid in 2003, which means they were underpaid in 2004 and currently are being underpaid. Moreover, their regression analyses clearly show a statistically significant teaching affect.

A teaching adjustment is long overdue for this payment system. Including a teaching adjustment will not rectify the past and current payment inequity. However, it will help ensure a more equitable system going forward. We urge the Agency to continue its commitment to empirically-based decisionmaking and include a teaching adjustment in the final rule.

II. CMS SHOULD RECONSIDER THE IME RESIDENT CAP PROPOSALS

To be consistent with the acute inpatient and psychiatric prospective payment systems, CMS is proposing to include a cap on the number of residents that could be counted for the IRF PPS teaching adjustment. The cap would be based on the number of residents reported by the IRP on the "final settlement of the IRF's most recent cost reporting period ending on or before November 15, 2003." (70 Fed. Reg. at 30243). Unlike the other payment systems, however, the proposed rule, if finalized, would preclude IRFs from entering into IME affiliation agreements. Such agreements allow facilities to aggregate their caps and redistribute them among themselves, so long as the aggregate number is not exceeded. In other words, one facility's cap may only increase if the other facility agrees to a corresponding reduced cap.

We have several concerns about CMS's proposals.

A. The Caps Should be Based on More Recent Data

We believe the cap determinations should be based on more recent data. We recognize CMS's desire to use historical data so that hospitals will not seek to increase their resident counts prior to application of the cap. However, under the Balanced Budget Act (BBA) legislation establishing the acute care caps, to ensure that the caps would be based on the most accurate historical resident count data possible, Congress required that CMS use data from hospital cost reports ending on or before December 31, 1996--nine months prior to the October 1, 1997 effective date. We see no reason why CMS should not employ a comparable standard and base the IRF caps on cost reporting periods ending in 2004, rather than 2003.

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concerns are solely theoretical. There are no data to support a conclusion that the "teaching affect" will be less as a result of the 75 percent rule. Teaching facilities should not be penalized until such time that the theory is disproved.

But perhaps most importantly, CMS's concern that teaching hospitals might inappropriately rotate rehabilitation residents to other locations or rotate other residents to rehabilitation units is without merit in principle. It is contrary to the fundamental commitment that the academic medicine community makes to ensuring that the educational needs of future physicians are met. This overriding and widespread commitment to medical education dominates the decisionmaking process of teaching hospitals.

C. CMS Should Use the IRF Resident Count as Reported on the Medicare Cost Reports

In computing the teaching adjustment, RAND used resident counts from the Medicare cost reports. For rehabilitation hospitals, this count is for the entire hospital; for units, the count is for the time residents spend in the rehabilitation unit. Specifically, the proposed rule states that RAND used the following variables from the cost report:

- Rehabilitation hospitals: Worksheet S-3, line 25, column 9 [Note that there appears to be a typographical error in the proposed rule in that no Part was listed for worksheet S-3. We presume that the correct cost report cite is Worksheet S-3, Part 1]

- Rehabilitation units of acute care hospitals: Worksheet S-3, Part 1, line 14 (or 14.01)

70 Fed. Reg. at 30242

CMS requests comments on "the most valid and reliable method of counting residents for purposes of a proposed teaching status adjustment." (70 Fed. Reg. at 30244). The proposed rule also states that:

> We are particularly interested in ensuring that the FTE resident counts used for the proposed IRF teaching status adjustment do not duplicate resident counts used for purposes of the IPPS IME adjustment and that hospitals do not have incentives to shift residents from the acute care hospital to the hospital's rehabilitation unit for purposes of computing the proposed IRF teaching adjustment.
>
> 70 Fed. Reg. at 30244.

We believe that CMS should use the cost report variables specified above to determine the IRF resident counts. For acute care hospitals, the cost report distinguishes between the time residents spend in the IPPS portion of the hospital and the rehabilitation unit. These counts are not duplicates. This result is verified by the Intern-and-Resident Information System (IRIS) files, which are used by fiscal intermediaries to ensure that resident counts are accurate and not duplicated across hospitals.

Historically, there has been no incentive to increase inappropriately the resident count in the rehabilitation unit because currently hospitals receive no IME payments associated

with these counts. Moreover, given that CMS plans to impose an IRF resident cap based on historical resident counts, hospitals have no payment incentive to shift additional residents from the inpatient acute portions of the hospital to their rehabilitation units. Such a shift would result in no payments because the additional residents would exceed the cap count and thus not be eligible for teaching adjustment payments. [2]

THE LOW-INCOME PAYMENT ADJUSTMENT

The IRF PPS currently includes a payment adjustment to account for differences in costs among IRFs associated with differences in the proportion of low-income patients (LIP) they treat. Based on the analyses conducted by RAND, CMS proposes to increase the LIP adjustment. We support this proposal and believe the adjustment should be increased in the final rule.

IRF DATA

Currently, CMS does not publish patient level data on IRF PPS case-mix group assignments. This greatly hampers the provider community and other researchers from doing empirical research on the IRF patient classification system and payment model which, in turn, hampers our ability to provide meaningful comments on proposed changes to the payment system. We urge CMS to publish these data.

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Thank you for this opportunity to present our views. We would be happy to work with CMS on any of the issues discussed above or other topics that involve the academic health care community.

If you have questions concerning these comments, please feel free to call Robert Dickler, Senior Vice President, Health Care Affairs, or Karen Fisher, Senior Associate Vice President. These individuals may be reached at (202) 828-0490.

Sincerely,

Jordan J. Cohen, M.D.

cc: Robert Dickler, AAMC
Karen Fisher, AAMC

[2] And, as discussed above, hospitals do not arbitrarily assign residents to various portions of the hospital. Such assignments are largely based on the education requirements associated with the resident's specialty.